

DEPT.-65

JOB-21

REEL-17

**CITY OF BALTIMORE**

**HEALTH DEPT.**

**BUREAU OF**

**VITAL STATISTICS**



**DEATHS**

**BEGINNING 1910**



CITY HALL  
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

## DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT  
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE  
DEPARTMENT OF Health BUREAU OF Vital  
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS  
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-  
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-  
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION  
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN  
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR  
ON JUNE 4, 1954.

## REQUEST FOR RETENTION PERIOD

To: Records Management Officer,  
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

## Record Identification

1. TITLE:  Certificate of Death		2. Form No. If available		3. Type—(cards, paper, etc.)  Bound Book	
4. Dates		5. Volume accumulated yearly		6. Size of Record Misc.	
				7. Number of copies made One (1)	
8. Authorization Requested (check only one (1) of the squares below)					
A. Establish retention period for records which are accumulating daily. <input type="checkbox"/>		B. Dispose of present accumulation, no additional accumulation anticipated. <input type="checkbox"/>		C. Microfilm and destroy originals. <input type="checkbox"/>	
				D. Microfilm and retain originals for length of time indicated below. <input checked="" type="checkbox"/>	
9. Recommended Retention Period			10. Equipment and space freed.		11. In your opinion does this record have any historical significance?
a. In Dept. 12 yrs.			b. In Storage Center Micro. Perm.		c. Total 12 yrs. and Micro. Perm.
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)					

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.  
Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

Robert E. Fairley, M.D.  
Title: Commissioner of Health

3/18/63  
Date

## Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept. 12 yrs.	b. In Storage Center Microfilm Permanent	c. Total 12 yrs. and Microfilm Permanent	A. To be sold as scrap or waste paper <input type="checkbox"/>	B. To be <input checked="" type="checkbox"/> Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>

REMARKS:

2 negative rolls

Records Management Officer

C. J. Force

3/19/63  
Date

## APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER  
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

**FILED ON FILM**

**IN**

**NUMERICAL ORDER**

# NOTICE

The succeeding documents  
were received in the same  
condition and microfilmed  
as shown.

Every effort was made to  
assure legibility and com-  
pleteness.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81431

## CERTIFICATE OF DEATH.

C81431

## PLACE OF DEATH

CITY OF BALTIMORE (No. 630 Bradley street, St. 17

WARD)

REGISTERED NO. C

## FULL NAME

James W. Johnson,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 630 Bradley street.

St. 15 yrs. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX,

Male,

## COLOR OR RACE,

Colored,

## SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married,

## DATE OF BIRTH,

March 15th, 1883.

(Month)

(Day)

(Year)

## AGE,

31 yrs. 9 mos. 13 ds.

## IF LESS than 1 day,

hrs. or min.?

## OCCUPATION:

(a) Trade, profession, or particular

kind of work

Day laborer.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

## BIRTHPLACE,

(State or Country),

Maryland,

PARENTS.  
NAME OF FATHER,

Unknown,

## BIRTHPLACE OF FATHER

(State or Country),

Unknown,

## MAIDEN NAME OF MOTHER

Unknown,

## BIRTHPLACE OF MOTHER

(State or Country),

Unknown.

## THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Sallie Johnson,

(Informant)

630 Bradley street.

(Address)

DEC 29 1914

Burial Permit Clerk

Filed 191

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## DATE OF DEATH,

December 27th, 1914.

(Month)

(Day)

(Year)

## I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

and that said deceased came to his death

(topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Tubercular peritonitis.

(Duration) yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

Dec. 28, 1914. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## UNDERTAKER

## ADDRESS



C81432

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81432

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *1125 Briscoe* ST. *21* WARD)2-FULL NAME *Maggie E. Robinson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1125 Briscoe* St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*4-COLOR OR RACE *Colored*5-SINGLE  
MARRIED *Married*  
WIDOWED  
OR DIVORCED  
(Write the word)6-DATE OF BIRTH *June 1858*

(Month)

(Day)

(Year)

7-AGE *46* yrs. mos. ds. or min.?If LESS than  
1 day, hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work *Domestic*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE  
(State or country) *Maryland*

PARENTS

10-NAME OF FATHER *Wm. Evans*11-BIRTHPLACE OF FATHER  
(State or country) *Maryland*12-MAIDEN NAME OF MOTHER *Carrie Hensley*13-BIRTHPLACE OF MOTHER  
(State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Stella Robinson*(Address) *1125 Briscoe St.*

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec 27, 1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 23, 1914*, to, *Dec 27, 1914*, that I saw her alive on *Dec 27, 1914*, and that death occurred, on the date stated above, at *11:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Apoplexy*

(Duration)

yrs.

mos.

*4* ds.Contributory  
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed) *Robert J. Green*

M. D.

*Dec 28, 1914*(Address) *120 1/2 Risquish St.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Auburn*DATE OF BURIAL *Dec 30, 1914*20-UNDERTAKER *John A. Toadorn*ADDRESS *147 W. 1st St.*

DEC 29 1914

Filed

191

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

TION is very important. See instructions on back of certificate.

C81433

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

C81433

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *532 N. Biddle* St. *17* WARD)2-FULL NAME *Eliza J. Gray*(Residence in Baltimore: No. *532 N. Biddle* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE *Married* MARRIED WIDOWED OR DIVORCED (Write the word)6-DATE OF BIRTH *unknown* 18*th* (Month) (Day) (Year)7-AGE *70* yrs. mos. ds. or min. If LESS than 1 day, hrs. min.8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *None*9-BIRTHPLACE (State or country) *Ind*10-NAME OF FATHER *Thos Marshall*11-BIRTHPLACE OF FATHER (State or country) *Ind*12-MAIDEN NAME OF MOTHER *Caroline Bailey*13-BIRTHPLACE OF MOTHER (State or country) *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Caroline Stoughton*(Address) *532 N. Biddle*

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec. 28 - 1914* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec. 18*, 191*4*, to *Dec 28*, 191*4*, that I saw *her* alive on *Dec. 28*, 191*4*, and that death occurred, on the date stated above, at *12:20* a.m. The CAUSE OF DEATH\* was as follows:*Cardiac insufficiency*(Duration) *1* yrs. *4* mos. ds.Contributory (SECONDARY) *Anginal Disease*(Duration) *2* yrs. — mos. — ds.(Signed) *E. J. Whalley* M. D.*12/29 - 1914* [Address] *1220 S. Howard*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Calver Baptist Church**12/29 1914*

20-UNDERTAKER

ADDRESS

*Sam'l S. Hensley* *532 N. Biddle*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

DEC 29 1914  
FiledHARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81434

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

28

C81434

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. \_\_\_\_\_)

2514 North Charles

ST. 17 WARD)

REGISTERED NO. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 2-FULL NAME

Cassie Matthews Reese

(Residence in Baltimore: No. \_\_\_\_\_)

2514 North Charles

St.: \_\_\_\_\_ yrs. 2 mos. 18 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

Dec.

23,

1867

(Month)

(Day)

(Year)

7-AGE

47

yrs.

-

mos.

5

ds.

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

John Thomas Matthews

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Melvin Woodland

13-BIRTHPLACE OF MOTHER (State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Raymond Matthews

(Address)

2514 N. Charles St.

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Dec.

28th,

1914

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 10th

1914, to

Dec. 28th

1914.

that I saw her alive on

Dec. 28th

1914.

and that death occurred, on the date stated above, at

7pm.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis  
Tuberculous meningitis  
Tuberculous infection

3+

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Dec. 28th, 1914

(Address)

Dr. J. H. Jones, M.D.  
Baltimore, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore County

Dec. 31, 1914

20-UNDERTAKER

H. E. Hughes

ADDRESS

11 N. Broadway

DEC 29 1914

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81435

## CERTIFICATE OF DEATH.

28 C81435

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1451 Henry St. ST.; 24 WARD)

## FULL NAME

Emma M. Remmey

## REGISTERED NO. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1451 Henry St.)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX

Female

## 4-COLOR OR RACE,

white

## 5-SINGLE,

MARRIED, widowed,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

## 7-AGE,

48 yrs. mos. da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

md.

## 10-NAME OF FATHER,

Wm. Walker

11-BIRTHPLACE OF FATHER  
(State or Country),

Balti

## 12-MAIDEN NAME OF MOTHER

Haines

13-BIRTHPLACE OF MOTHER  
(State or Country),

Balti

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

DEC 29 1914

HARRY O. ANDREWS,  
Burial Permit Clerk.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 27<sup>th</sup>, 1914.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from her 1<sup>st</sup> 1914, to Dec 27<sup>th</sup> 1914, that I saw her alive on Dec 27<sup>th</sup> 1914, and that death occurred, on the date stated above, at 9:40 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. H. M. D.

Dec 28<sup>th</sup>, 1914. (Address) 1425 Light St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem

## DATE OF BURIAL,

Dec 31, 1914

## 20-UNDERTAKER

Jas. J. Calverley

## ADDRESS

138 Light St.

Important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1603 Ludlow* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James R. Goldstraw Jr.*(Residence in Baltimore: No. *1603 Ludlow* St.; *3* yrs., *3* mos., *18* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, *Sept 25, 1914*  
(Month) (Day) (Year)7-AGE, *3* yrs., *2* mos., *7* ds.  
If LESS than 1 day,  
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *James R Goldstraw*11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*12-MAIDEN NAME OF MOTHER *Mary Simms*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Goldstraw*(Address) *1603 Ludlow St.*

15-

Filed *DEC 29 1914*HARRY O. ANDERSON  
Baptist Permit 0151  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *12* *28*, *1914*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 12* 1914, to *Dec 28* 1914, that I saw him alive on *Dec 27* 1914, and that death occurred, on the date stated above, at *10:45 PM*.

The CAUSE OF DEATH\* was as follows:

*Meningo-Myelocile*(Duration) *3* yrs., *3* mos., *18* ds.CONTRIBUTORY *Meningitis*  
(Secondary)(Duration) *about* *10* mos., *10* ds.(Signed) *Maurice Jones* M. D.*Dec 28* 1914. (Address) *423 E. Fort St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cem*DATE OF BURIAL, *Dec 29*, 1914.20-UNDERTAKER *John J. Fahy & Son*ADDRESS *1318 Right St*

C81437 HEALTH DEPARTMENT—CITY OF BALTIMORE

C81437

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1818 E. North ave.* St. *—* yrs. *—* mos. *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Widowed**WIDOWED,**OR DIVORCED,**(Write the word.)*

## 6-DATE OF BIRTH,

*Don't know*

(Month)

(Day)

(Year)

## 7-AGE,

*76 years*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Carpenter*9-BIRTHPLACE,  
(State or Country),*Germany*

## 10-NAME OF FATHER,

*Henry Wolfe*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Erdman*(Address) *1818 E. North ave.*

## 15-

Filed

DEC 29 1914

191

HARRY O. ANDERSON  
Serial Permit Clerk  
Contrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Dec 26*

(Month)

(Day)

*1914*  
(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 26 (3 A.M.) 1914, to Dec 26 (7 P.M.) 1914,*that I saw him alive on *Dec 26* 1914.and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Infectious Myelitis*CONTRIBUTORY  
(Secondary)*Asphyctic Pneumonia*  
(Duration) *3* yrs. *—* mos. *—* ds.(Signed) *J. H. Warner* M. D.*Dec 26, 1914* (Address) *St. Josephs Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *1* ds. *—* In the State *—* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *1818 E. North ave.*Former or usual residence *1818 E. North ave.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Cemetery*

## DATE OF BURIAL,

*Dec 29 1914*

## 20-UNDERTAKER,

*George J. Ruth*

## ADDRESS

*1735 Hayford Ave.*



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. *1927 Aliceanna* ST.: *2* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
FULL NAME *Walter Mazelski*  
(Residence in Baltimore: No. *1927 Aliceanna* St.: *from birth* yrs., mos. ds.)

REGISTERED NO. C

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*  
6-DATE OF BIRTH, *October 3rd, 1914* (Month) (Day) (Year)

7-AGE, *2 yrs., 24 mos., 24 ds.* If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Md. (City)*

PARENTS.  
10-NAME OF FATHER, *Victor Mazelski*  
11-BIRTHPLACE OF FATHER (State or Country), *Russia*  
12-MAIDEN NAME OF MOTHER, *Gurzel*  
13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Mariana Mazelski*  
(Address) *1927 Aliceanna*

15-  
Filed....., 191.....  
HARRY O. ANDREWS, Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *December 28th, 1914* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

*Gastro Enteritis*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary).....  
(Duration) .... yrs. .... mos. .... ds.  
(Signed) *William M. Savage* M. D. (Coroner.)  
*Dec. 28*, 1914 (Address) *1729 Madison Ave.*

\*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Holy Rosary* DATE OF BURIAL, *Dec 29, 1914*

20-UNDERTAKER, *M. F. Sadowski* ADDRESS *405 V. Avenue*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

C81439

## CERTIFICATE OF DEATH

C81439

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *207 Aisgwith*)

ST. *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME *Maggie L Sanks*

(Residence in Baltimore: No. *207 Aisgwith*)

St. *48* yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *colored* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *widow* (If write the word)

6 DATE OF BIRTH *January 12*, 18*66* (Month) (Day) (Year)

7 AGE *48* yrs. *11* mos. *15* ds. or — min. ? If LESS than 1 day, — hrs.

8 OCCUPATION (a) Trade, profession, or particular kind of work *domestic housework* (b) General nature of industry, business, or establishment in which employed (or employer) *none*

9 BIRTHPLACE (State or country) *Baltimore*

10 NAME OF FATHER *Benjamin Laws*

11 BIRTHPLACE OF FATHER (State or country) *Baltimore*

12 MAIDEN NAME OF MOTHER *Lydia Johnson*

13 BIRTHPLACE OF MOTHER (State or country) *Baltimore*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Laurie Laws*

(Address) *802 Druid Hill Ave*

15 DEC 29 1914

Filed 191

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 27*, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec 27*, 1914, to *Dec 27*, 1914 that I saw him alive on *Dec 27*, 1914 and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

*Nephritis (Bright's Disease) Emergency call*

Contributory *urinary congestion* (SECONDARY) *et hemorrhage* (Duration) yrs. mos. ds.

(Signed) *J. S. Howard* M. D. *Dec 28*, 1914. (Address) *Aisgwith St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt. Auburn Cem.*

*12/29/1914*

20 UNDERTAKER

ADDRESS

*Theodore White*

*1702 South*

C81440

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

92 C81440

## PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1636 W Baltimore

ST. 19

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ellen J. Cloney

Residence in Baltimore: No.

1636 W Baltimore

St.: yrs. mos. 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widow

6-DATE OF BIRTH

Dec

25,

1837

(Month)

(Day)

(Year)

7-AGE

77

yrs.

mos.

3

ds.

If LESS than  
1 day, hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession, or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF  
FATHER

Thomas Slattery

11-BIRTHPLACE  
OF FATHER

(State or country)

Ireland

12-MAIDEN NAME  
OF MOTHER

Catherine Connor

13-BIRTHPLACE  
OF MOTHER

(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs K. J. Devore

(Address)

26 Glendale St. Brooklyn

DEC 29 1914

Filed

191

HARRY O. ANDREWS,

Barial Permit Clerk

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Dec

28,

1914

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

Dec 23

191

to,

Dec 28

1914

that I saw him alive on Dec 28, 1914

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchitis &amp; Lobular Pneumonia

(Duration) yrs. mos. 5 ds

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Marshall S. Smith

M. D.

Dec 29, 1914

(Address)

118 W Calhoun

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boston Mass

Dec 29, 1914

20-UNDERTAKER

ADDRESS

Jas R. Cook

1003 W. Pratt

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81441

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

64 C81441  
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 Wilson St. 14 WARD)

2-FULL NAME Margaret Klings

(Residence in Baltimore: No. 548 Wilson St.)

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED Married  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

Unknown 1871  
(Month) (Day) (Year)

7-AGE

43 yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE  
(State or country)

md

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Hechder

Germany

not known

not known

George A. Kling  
548 Wilson St.

## MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Dec 26, 1914  
(Month) (Day) (Year)

11-I HEREBY CERTIFY, That I attended deceased from Dec 24, 1914, to Dec 26, 1914,

that I saw him alive on Dec 26, 1914,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

Contributory (SECONDARY) Arterio-sclerosis  
(Duration) yrs. mos. ds.(Signed) John B. Stange M. D.  
Dec 29, 1914 (Address) 716 N. W. Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Dec 29, 1914

20-UNDERTAKER

Daniel Carlson

ADDRESS

716 N. W. Ave

DEC 29 1914

FRI

HARRY O. ANDREWS,

Bureau Permit Clerk,  
REGISTRAR

TION is very important. See instructions on back of certificate.



CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

C81442

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *23* WARD)

2-FULL NAME

*Daniel C. Walker*

(Residence in Baltimore: No. *1224 Nauvoo* St.; yrs. *from* mos. *none* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widowed*

6-DATE OF BIRTH

*May 3<sup>rd</sup> 1868*  
(Month) (Day) (Year)

7-AGE

*46* yrs. *7* mos. *24* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Glassblower*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

*D. C. Md.*

10-NAME OF FATHER

*John C. Walker*

11-BIRTHPLACE OF FATHER, (State or Country)

*Md.*

12-MAIDEN NAME OF MOTHER

*Elizabeth McCracken*

13-BIRTHPLACE OF MOTHER, (State or Country)

*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John J. Walker*

(Address) *1224 Nauvoo*

DEC 29 1914

HARRY O. ANDREWS,

Filed..... 191... *Barial Permit Clerk* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*December 27<sup>th</sup> 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*  
(Duration) *8* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(Signed) *Wm. M. Savage* M. D. (Coroner.)  
*Dec 29* 1914 (Address) *1224 Nauvoo*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *14* yrs. *0* mos. *0* ds. State *14* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death? *Evening House*

Former or usual residence *1224 Nauvoo*

19-PLACE OF BURIAL OR REMOVAL

*Bedar Hill Cem*

DATE OF BURIAL

*Dec. 30, 1914*

20-UNDERTAKER

*Mrs. J. E. Evanson*

ADDRESS

*1408 S. Charles*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81443

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 717 N. Pulaski st. St. 16 WARD)

2-FULL NAME Eva E. Hartman, \*

(Residence in Baltimore: No. 717 N. Pulaski st. St.; yrs., mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female, 4-COLOR OR RACE, White; 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, April 6th, 1853. (Month) (Day) (Year)

7-AGE, 61 yrs., 8 mos., 22 ds. If LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, John Eisenroth,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant), Anna J. Hartman,

(Address), 717 N. Pulaski st.

15-DEC 29 1914 HARRY O. ANDREWS, Registrar.

Filed, 191... Special Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1914. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidentally asphyxiated by illuminating gas.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick H. Campbell, M. D. (Coroner.)

Dec. 28, 1914 (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Dec. 30, 1914.

20-UNDERTAKER, ADDRESS, Stewart Mowen Co 10820 North Ave



C81444

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81444

PLACE OF DEATH

CITY OF BALTIMORE (No. 551 W. Lafayette ave. ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jarbet E. Woodson,

(Residence in Baltimore: No. 551 W. Lafayette ave.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, October 9th., 1914. (Month) (Day) (Year)

7-AGE, 0 yrs., 2 mos., 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, James Woodson,

11-BIRTHPLACE OF FATHER (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Kate Nutt,

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Nutt,

(Address) 551 W. Lafayette ave.

15- HARRY O. ANDREWS, Registrar, DEC 29 1914, Burial Permit.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1914. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Gastro-enteritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY Artificial feeding, (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick Hempel M. D.

(Coroner) Dec. 29, 1914 (Address) 1103 Valley St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Peter's Cemetery, Dec. 29, 1914

20-UNDERTAKER, ADDRESS

Charles C. Wright, 13647 Carey St

Important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81446

C81446

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Riverside Ave. ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1220 Riverside Ave St.; yrs. mos. 3 1/2 hrs. 2)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH,

Dec 28, 1914  
(Month) (Day) (Year)

## 7-AGE,

yrs. mos. 3 1/2IF LESS than 1 day.  
3 hrs. or 30 min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

Maryland

## 10-NAME OF FATHER,

John A. Bernierie

## 11-BIRTHPLACE OF FATHER,

(State or Country), Maryland

## 12-MAIDEN NAME OF MOTHER,

Eleonora Fortman

## 13-BIRTHPLACE OF MOTHER, (State or Country),

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Bernierie(Address) 1220 Riverside Ave.

## 15-

Filed

DEC 29 1914

HARRY O. ANDREWS,

Berial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 28, 1914  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 28 1914, to Dec 28 1914, that I saw her alive on Dec 28 1914, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH\* was as follows:

Atelectasis

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. B. Harle12/28/14, 1914 (Address) 301 E. Cross St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Cross A.C.C.

## DATE OF BURIAL,

12-29, 1914

## 20-UNDERTAKER

E. B. Harle

## ADDRESS

115 E. West St.

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40

C81447

PLACE OF DEATH

CITY OF BALTIMORE (No. *236 S Eden*)

ST. *3*

WARD

FULL NAME

*Osaac Mullen*

(Residence in Baltimore: No. *236 S Eden*)

ST. *3*

yrs. *18*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

6. DATE OF BIRTH

*Unknown*, 1

7. AGE

*62* yrs. *1* mos. *18* ds.

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Sailor*

9. BIRTHPLACE

(State or country)

*Russia*

10. NAME OF FATHER

*Nathan Mullen*

11. BIRTHPLACE OF FATHER (State or country)

*Russia*

12. MAIDEN NAME OF MOTHER

*Unknown*

13. BIRTHPLACE OF MOTHER (State or country)

*Russia*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Hyman Hurwitz*

(Address)

*236 S Eden St*

15.

DEC 29 1914

HARRY O. ANDREWS,  
Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Dec 29<sup>th</sup>*, 1914

17. I HEREBY CERTIFY, That I attended deceased from

*Nov 5<sup>th</sup>*, 1914, to *Dec 12<sup>th</sup>*, 1914.

that I saw him alive on *Dec 12<sup>th</sup>*, 1914.

and that death occurred, on the date stated above, at *4<sup>40</sup>* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of the Liver  
& Valvular Disease of the heart*

*Diagnosis* (Duration) yrs. *8* mos. *1* ds.

Contributory *Diphtheria*

(SECONDARY) (Duration) yrs. *1* mos. *1* ds.

(Signed) *W. H. Hoff, M.D.* M. D.

*191* (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. *1* mos. *1* ds. In the State yrs. *1* mos. *1* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence *236 S Eden St*

19. PLACE OF BURIAL OR REMOVAL

*Hebrew Belair Rd*

DATE OF BURIAL

*Dec 29, 1914*

20. UNDERTAKER

*J. L. Linn + Bro Balto St*

ADDRESS

*1107 E*



# 081448 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *804 Maugold* ST. *21* WARD)

2-FULL NAME

(Residence in Baltimore: No. *804 Maugold* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

*Unknown, 1*  
(Month) (Day) (Year)

7-AGE

*52* yrs. mos. ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *Lewis Bothe*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Bothe*

(Address) *804 Maugold St.*

15-DEC 29 1914 ROBERT . KRAUTER, Serial Permit Clerk, Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Dec 26, 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* and that said deceased came to *death* (death, topsy or inquiry) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Strangulation by Larynx*  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Jeffers* M. D.

*Dec 29 1914* (Address) *113 N. Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

*Wood Hill Park*

DATE OF BURIAL,

*Dec 29, 1914*

20-UNDERTAKER

*John Brown*

ADDRESS

*901 Hollist*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81449

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81449

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1432 Woodall*.ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Annie M. Witzke*(Residence in Baltimore: No. *1432 Woodall*.

St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

~~MARRIED~~

WIDOWED,

OR DIVORCED,

(Write the word.)

*Married*

10-DATE OF DEATH,

*Dec. 27, 1914.*  
(Month) (Day) (Year)

6-DATE OF BIRTH,

*July 1, 1890.*  
(Month) (Day) (Year)

7-AGE,

*24 yrs. 5 mos. 27 ds.*

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*House-Wife*9-BIRTHPLACE,  
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Joseph H. Nash.*11-BIRTHPLACE OF FATHER  
(State or Country),*Balto. Md.*

12-MAIDEN NAME OF MOTHER

*Laura V. Marrison.*13-BIRTHPLACE OF MOTHER  
(State or Country),*Id.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*John P. Witzke*

(Address)

*1432 Woodall St.*

15-

DEC 29 1914

Filed 191

ROBERT J. KRAUTER,

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

*Sep 25 1914, to Dec 27 1914.*that I saw him alive on *Dec 27 1914.*and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(Duration) yrs. *3* mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*R. P. Campbell, M. D.**Dec 28 1914* (Address) *1644 Hawthorn*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Oliver Cem.**Dec. 30, 1914.*

UNDERTAKER

ADDRESS

*Edw. J. Fanning, 1460 Baltimore*

important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 208 Pine

ST. 4

WARD)

FULL NAME

Edward Campbell

(Residence in Baltimore: No. 208 Pine St

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married,

DATE OF BIRTH

Aug 3, 1883

(Month) (Day) (Year)

AGE

31

yrs.

4

mos.

25

ds.

If LESS than  
1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Laborer

BIRTHPLACE

(State or country)

Balto. Md

NAME OF FATHER

Charles Campbell

BIRTHPLACE OF FATHER

Balto. Md.

MAIDEN NAME OF MOTHER

Annie Dukurst

BIRTHPLACE OF MOTHER

Balto. Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Campbell

(Address)

208 N. Pine St

DEC 29 1914

Filed

ROBERT KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 28, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Nov 18, 1914, to Dec 28, 1914.

that I saw him alive on Dec 27, 1914.

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the  
Stomach

(Duration) yrs. 8 mos. ds.

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R B Kenyon M. D.

Dec 28, 1914 (Address) 422 S Green

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

Baltimore, Md  
E. B. Burial Society

DATE OF BURIAL

Dec 31, 1914

UNDERTAKER

E. E. Manning

ADDRESS

1938 E. Lafayette

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81451

## CERTIFICATE OF DEATH

29 C81451

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *H. Elizabeth House* ST. *4* WARD)2-FULL NAME *Francis Rutland*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Paul St.* St. *4* yrs. *2* mos. *24* ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male*4-COLOR OR RACE *colored*5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)6-DATE OF BIRTH *Oct 3, 1914*

(Month)

(Day)

(Year)

7-AGE *2 24*

yrs.

mos.

ds.

If LESS than  
1 day, hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec 27, 1914*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Dec 13, 1914* to *Dec 27, 1914*, that I saw him alive on *Dec 26, 1914*, and that death occurred, on the date stated above, at *9* m.

The CAUSE OF DEATH\* was as follows:

*Acute Infectious Tuberculosis*(Duration) yrs. *1* mos. *2* ds.Contributory  
(SECONDARY)(Signed) *Edgar B. ...* M. D.*Dec 27, 1914* [Address] *1616 ...*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. *2* mos. *14* ds. In the State yrs. *2* mos. *24* ds.Where was disease contracted, if not at place of death? *Probably contracted at place of death.*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL *DEC 29 1914*

20-UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

15-  
DEC 29 1914  
Filed ... 191

UNIVERSITY OF MARYLAND.

ROBERT . KRAUTER

Burial Permit Clerk

21-PHYSICIAN Health.

FOR ANATOMICAL PURPOSES

C81452

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

64

C81452

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1907 E. Fairmount

ST. 6 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

John W. Etchberger

(Residence in Baltimore: No.

1907 E. Fairmount

St. yrs. moa. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Widower

## 6-DATE OF BIRTH,

April 3, 1849

(Month) (Day) (Year)

## 7-AGE,

63 yrs. 8 mos. 21 da.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Carpenter  
House9-BIRTHPLACE,  
(State or Country),

Baltimore

## 10-NAME OF FATHER,

Ralph Etchberger

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore

## 12-MAIDEN NAME OF MOTHER

Mary William

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Roy Etchberger

(Address).

1907 E. Fairmount

## 15-

DEC 29 1914

ROBERT . KRAUTER,

Filed DEC 29 1914, by Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 28, 1914

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
DEC 25 1914, to DEC 28 1914,  
that I saw him alive on DEC 27 1914,  
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) yrs. moa. da.

CONTRIBUTORY  
(Secondary)

Cerebral Hemorrhage

(Duration) yrs. moa. da.

(Signed)

Geo. Heller

M. D.

DEC 29 1914 (Address) 1927 Gough St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. moa. da. In the State yrs. moa. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Greenmount

## DATE OF BURIAL,

Dec 30, 1914

## 20-UNDERTAKER

Junkler &amp; Junkler

ADDRESS

1739 E. Eager

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81453

## CERTIFICATE OF DEATH.

79 C81453

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3040 Dillon

ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Frederick Parker

(Residence in Baltimore: No.

3040 Dillon

St. 40 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

July 17, 1848

(Month) (Day) (Year)

7-AGE,

66 yrs. 5 mos. 11 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer).

Electrical

9-BIRTHPLACE,  
(State or Country),

England.

10-NAME OF  
FATHER,

Samuel Parker.

11-BIRTHPLACE  
OF FATHER  
(State or Country),

England

12-MAIDEN NAME  
OF MOTHER

Mary Young.

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Justina Parker

(Address)

3040 Dillon

15-

DEC 29 1914

ROBERT KRAUTER,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec. 28, 1914.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. - - - 1914, to Dec 28 1914.

that I saw him alive on Dec 28 1914.

and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH\* was as follows:

V. rema - in  
cardiac dilatation

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

Cardiac Hypertrophy

(Duration) 2 yrs. mos. da.

(Signed) J. M. D.

Dec. 29, 1914. (Address) Elwood Ave. &amp; D. M. D. 4.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REPOSAL

Borden Park

DATE OF BURIAL

Dec. 31, 1914

20-UNDERTAKER

Fickler &amp; Fickler

ADDRESS

1739 E. Eager

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *221 S. Wolfe* ST. *2* WARD)2-FULL NAME *John Lewandowski*(Residence in Baltimore: No. *221 S. Wolfe* St.; *23* yrs., *7* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Married*

6-DATE OF BIRTH,

*May*

(Month)

(Day)

*1891*  
(Year)

7-AGE,

*23* yrs., *7* mos., *0* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer).

*General*

9-BIRTHPLACE,

(State or Country).

*Baltimore, Md.*

10-NAME OF FATHER,

*Thomas Lewandowski*

11-BIRTHPLACE OF FATHER

(State or Country).

*German Poland*

12-MAIDEN NAME OF MOTHER

*Francis Krusek*

13-BIRTHPLACE OF MOTHER

(State or Country).

*German Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Thomas Lewandowski*

(Address)

*221 S. Wolfe St.*

15-

*DEC 29 1914**ROBERT KRAUTER,**Bureau Permit Clerk*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*December 28 1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec. 1* 1914, to *Dec. 28* 1914,that I saw him alive on *Dec. 27*, 1914,and that death occurred, on the date stated above, at *7 p.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Tuberculosis*(Duration) *1* yrs., *0* mos., *0* ds.

CONTRIBUTORY

(Secondary)

*Failure* (Duration) *1* yrs., *0* mos., *0* ds.(Signed) *G. C. R. R. R.**12/29/1914* (Address) *221 S. Wolfe St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Stanislaus* *Dec 31*, 1914

20-UNDERTAKER

ADDRESS

*M. F. Sadowski* *405 S. Long*

important. See instructions on back of certificate.

C81455

## HEALTH DEPARTMENT—CITY OF BALTIMORE

321

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

West End Maternity Hosp

REGISTERED NO. C

CITY OF BALTIMORE: (No.

112 N Calhoun

ST.;

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Brass

(Residence in Baltimore: No.

112 N. Calhoun

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Dec

28, 1914.

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

6 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

William Brass Jr.

11-BIRTHPLACE

OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Lillian Lewis

13-BIRTHPLACE

OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. Brass

(Address)

1109 Scott St

15-

DEC. 29 1914

ROBERT . KRAUTER,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

December

29,

1914.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 28 1914, to Dec 29 1914,

that I saw him alive on Dec 29 1914,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH\* was as follows:

Congenital atelectasis following  
premature delivery for 6 hrs  
e. clamps (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Premature birth

(Duration) yrs. mos. ds.

(Signed)

A. Lee. Hieber

M. D.

12/29/1914. (Address) Franklin St. 2nd fl.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1209 Scott St.

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet

DATE OF BURIAL,

DEC 29 1914

20-UNDERTAKER

Jas. L. Liguori

ADDRESS

1000 E. Ave

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81456

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *445 W 23rd St.* ST. *12* WARD)

2-FULL NAME *Thomas West*

(Residence in Baltimore: No. *445 W 23rd St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *Colored*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *March*, *1869*

(Month)

(Day)

(Year)

7-AGE *45*

Yrs. *10* Mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Labourer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Pa.*

10-NAME OF FATHER, *W. West*

11-BIRTHPLACE OF FATHER (State or Country), *Pa.*

12-MAIDEN NAME OF MOTHER *Susan Keeler*

13-BIRTHPLACE OF MOTHER (State or Country), *Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. West*

(Address) *2402 Buchanan St.*

DEC 29 1914

ROBERT T. KRAUTER,

Filed *Serial Permit* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec*, *28*, *1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* and that said deceased came to death *on the day stated above.* (Inquest, autopsy or inquiry.)

THE CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Harry E. Allen* M. D.

(Coroner) *Harry E. Allen*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Green Cemetery*

DATE OF BURIAL, *DEC 30*, 1914

20-UNDERTAKER *Sam'l H. Chase Son*

ADDRESS *1400 Market St.*



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificate.

C81457

HEALTH DEPARTMENT--CITY OF BALTIMORE

28 C81457

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1917 Bunt St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Taylor

Residence in Baltimore: No.

1917 Bunt St.

St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

Mar. 17<sup>th</sup> 1907

7-AGE

7 yrs. 9 mos. 11 ds. or 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE  
(State or country)

A. G. Co Ind.

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER  
(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Maggie Taylor

13-BIRTHPLACE OF MOTHER  
(State or country)

A. G. Co Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Taylor

(Address)

1917 Bunt St

16-DATE OF DEATH

Dec 28 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 15, 1914, to, Dec 28 1914,

that I saw him alive on Dec 28 1914,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of Lungs

Contributory  
(SECONDARY)

Cardiac Asthenia  
(Duration) yrs. 4 mos. ds.

(Signed),

E. William Fry M. D.

Dec 28 1914 [Address] 1928 Penna Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lane

Dec 30 1914

20-UNDERTAKER

ADDRESS

George H. Holland 577 Robert St

DEC 29 1914  
Filed

ROBERT J. KRAUTER,  
Burial Permit Clerk,  
REGISTRAR



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81458

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81458

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1602 E. Chase*)

ST. *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *August Orth*

(Residence in Baltimore: No. *1602 E. Chase*)

St. *5* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widowed*  
(Write the word)

6 DATE OF BIRTH *Sept. 15, 1838*  
(Month) (Day) (Year)

7 AGE *76* yrs. *3* mos. *12* ds. or min. ? If LESS than 1 day, hrs.

8 OCCUPATION *Retired Farmer*  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE *Germany*  
(State or country)

10 NAME OF FATHER *Louis Orth*

11 BIRTHPLACE OF FATHER *Germany*  
(State or country)

12 MAIDEN NAME OF MOTHER *Mary Elizabeth Wisting*

13 BIRTHPLACE OF MOTHER *Germany*  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Elizabeth C. Starny*

(Address) *1602 E. Chase St.*

15. *DEC 29 1914* *ROBERT . KRAUTER,*  
Filed *Serial Permit Clerk.*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 27, 1914*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 22*, 1914, to *Dec 27*, 1914, that I saw him alive on *Dec 27*, 1914, and that death occurred, on the date stated above, at *11:40* a.m. The CAUSE OF DEATH\* was as follows:

*Acute dilatation of heart*

(Duration) yrs. mos. ds. *6*  
Contributory *Chronic Valvular Heart*  
(SECONDARY) *seen* (Duration) yrs. mos. ds. *6*  
(Signed) *A. L. Hornstein* M. D.  
*12/29*, 1914. (Address) *733 Aisquith St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, .  
If not at place of death?  
Former or usual residence

PLACE OF BURIAL OR REMOVAL *Highland Park* DATE OF BURIAL *Dec 31, 1914*

20 UNDERTAKER *Joseph B. Cook* ADDRESS *1003 W. Balto St.*

C81459

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

79 ..C81459  
REGISTERED NO. C

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *3* WARD)

## FULL NAME

(Residence in Baltimore: No. *211 S. Bond* St.; - yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 1-SEX

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Widow*

## 6-DATE OF BIRTH,

*May 4*, 18*43*  
(Month) (Day) (Year)

## 7-AGE,

*71* yrs. *7* mos. *24* ds.If LESS than 1 day,  
... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*Retired*9-BIRTHPLACE,  
(State or Country),*Ireland*10-NAME OF  
FATHER,*Unknown*11-BIRTHPLACE  
OF FATHER  
(State or Country),*Ireland*12-MAIDEN NAME  
OF MOTHER*Unknown*13-BIRTHPLACE  
OF MOTHER  
(State or Country),*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Leary*(Address) *2572 W. Pratt St.*

DEC 30 1914

GARRY O. ANDREWS,

Filed....., 191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Dec 28*, 191*4*  
(Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from  
*February 12* 191*3*, to *Dec 28* 191*4*,  
that I saw her alive on *Dec 28* 191*4*,  
and that death occurred, on the date stated above, at *8:30 A.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Endocarditis and*  
*Myocarditis*(Duration) *5* yrs. *6* mos. *6* ds.CONTRIBUTORY  
(Secondary)(Duration) *6* hrs.(Signed) *W. H. Warner* M. D.*Dec 28*, 191*4*. (Address) *St. Joseph's Hosp.*

\*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *10* mos. *14* ds. In the State *—* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *211 S. Bond St.*Former or usual residence *211 S. Bond St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*New Cathedral*

## DATE OF BURIAL,

*Dec. 30*, 191*4*.

## 20-UNDERTAKER

*Lilly & Zieglar*

## ADDRESS

*403 S. Wolfe St.*

important. See instructions on back of certificate.

C81460

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

120 C81460

PLACE OF DEATH Mercy Hospital ST. 1 WARD

CITY OF BALTIMORE: (No. 124 S. Reber son St.; yrs. mos. ds.)

FULL NAME James A. Fletcher

(Residence in Baltimore: No. 124 S. Reber son St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Married  
MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH, Unknown, 1871  
(Month) (Day) (Year)

7-AGE, 48 yrs. - 1 mos. - 1 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, James A. Fletcher

11-BIRTHPLACE OF FATHER, (State or Country), U. S. A.

12-MAIDEN NAME OF MOTHER, Virginia Arey

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Harry O. Andrews  
(Address) 2019 Gough St.

15-DEC 30 1914 HARRY O. ANDREWS,  
Filed Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1914, to Dec 27 1914, that I saw him alive on Dec 27 1914, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Chronic Pneumonia  
Nephritis

Do not know  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) Lobar Pneumonia  
absent  
(Duration) yrs. mos. ds.  
(Signed) Frank M. M... M. D.  
Dec 27, 1914 (Address) Mercy Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death yrs. mos. 1 da. In the State yrs. mos. ds. life

Where was disease contracted, if not at place of death? 124 S. Reber son  
Former or usual residence 124 S. Reber son

19-PLACE OF BURIAL, OR REMOVAL, Landon Park DATE OF BURIAL, Dec 30, 1914

20-UNDERTAKER Lilly Zeien ADDRESS 4033 Wolfe St.

important. See instructions on back of certificate.



C81461

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81461

## CERTIFICATE OF DEATH.

PLACE OF DEATH  
 CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 5 WARD)  
 FULL NAME *Jeanette Stanodup*  
 (Residence in Baltimore: No. *1226 St. Matthew St.* St. *5* yrs., *5* mos., *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*  
 4-COLOR OR RACE, *White*  
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*  
 (Write the word.)  
 6-DATE OF BIRTH, *July*, 1911  
 (Month) (Day) (Year)  
 7-AGE, *2* yrs., *5* mos., *5* ds.  
 If LESS than 1 day, .... hrs. or .... min.  
 8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work, *None*  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*

10-NAME OF FATHER, *Unknown*  
 11-BIRTHPLACE OF FATHER (State or Country), *Russia*  
 12-MAIDEN NAME OF MOTHER, *Unknown*  
 13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *F. Phelps*

(Address), *Johns Hopkins Hosp.*

15-DEC 30 1914 HARRY O. ANDREWS,  
 Filed Serial Permit Clerk  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *December 29*, 1914  
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Dec 28* 1914, to *Dec 29* 1914, that I saw her alive on *Dec 29* 1914, and that death occurred, on the date stated above, at *8:10* p. m.

The CAUSE OF DEATH\* was as follows:

*General septicæmia*  
*Septicæmia*

(Duration) .... yrs. .... mos. *4* ds.

CONTRIBUTORY (Secondary) *Acute Osteomyelitis*

(Duration) *X* yrs. .... mos. *7* ds.

(Signed) *C. H. Watt* M. D.

*Dec 30*, 1914 (Address), *Johns Hopkins Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. *2* ds. In the *1 1/2* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1226 St. Matthew St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Northmen Avenue* *Dec 30*, 1914

20-UNDERTAKER,

*Jack Lewis*

ADDRESS

*1419 5th Ave*

Important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81462

## CERTIFICATE OF DEATH.

66 C81462

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1118 Russell

ST.: 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Fannie Jackson

(Residence in Baltimore: No.

1118 Russell St.

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

## 6-DATE OF BIRTH,

June 26, 1839

(Month) (Day) (Year)

## 7-AGE,

75 yrs. 6 mos. 1 da.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

Maryland

## 10-NAME OF FATHER,

Charles Cornish

## 11-BIRTHPLACE OF FATHER

(State or Country),

Md

## 12-MAIDEN NAME OF MOTHER

Sarah Tubman

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Dixon

(Address) 1118 Russell St.

## 15-

DEC 30 1914

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec. 27, 1914

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1914, to Dec. 27, 1914, that I saw her alive on Dec. 27, 1914, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Paralysis (Heart) Immediate Exhaustion

(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. P. Starnes M. D.

12/29/1914 (Address) 528 Hammond St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Laurel St

## DATE OF BURIAL,

Dec. 30, 1914

## 20-UNDERTAKER

J. E. Broadwell Son

## ADDRESS

125 W. North St.

C81463

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81463

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *415 Myrtle Ave* ST. *17* WARD)2-FULL NAME *Joseph A. Green*Residence in Baltimore: No. *415 Myrtle* St. *50* yrs.  mos.  ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Married*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)6-DATE OF BIRTH *Unknown, 1864*  
(Month) (Day) (Year)7-AGE *50* yrs.  mos.  ds. or  min.?  
If LESS than 1 day, hrs.8-OCCUPATION  
(a) Trade, profession or particular kind of work *Ironworker*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *md*PARENTS  
10-NAME OF FATHER *Joseph Green*  
11-BIRTHPLACE OF FATHER *Germany*  
(State or country)  
12-MAIDEN NAME OF MOTHER *Not known*  
13-BIRTHPLACE OF MOTHER *Not known*  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Bertha Green*  
(Address) *415 Myrtle Ave*15-DEC 30 1914  
FiledHARRY O. A. *Serial Permit Clerk*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec. 28th, 1914*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec. 15th, 1914*, to *Dec. 27th, 1914*,  
that I saw him alive on *Dec. 27th, 1914*,  
and that death occurred, on the date stated above, at *3:25 a. m.*THE CAUSE OF DEATH\* was as follows:  
*Pulmonary Tuberculosis*  
*Toxaemia & Asthenia*18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]  
(Duration) *2* yrs.  mos.  ds.  
Contributory *Lobar Pneumonia*  
(SECONDARY)  
*Chronic nephritis* *1* yrs.  mos.  ds.  
(Signed) *W. F. McLeachy* M. D.  
*Dec. 28th, 1914.* [Address] *656 W. Drayton St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death  yrs.  mos.  ds. State  yrs.  mos.  ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral Ave* DATE OF BURIAL *Dec. 31, 1914*20-UNDERTAKER *Daniel Carlson* ADDRESS *916 Penna ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

634 Portland

ST.

WARD)

George Gundlach

634 Portland

St.; yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH.

February 28, 1830

7-AGE.

84 yrs. 10 mos. - ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Shoe-maker

9-BIRTHPLACE.

(State or Country).

Germany

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER.

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Unknown

13-BIRTHPLACE OF MOTHER.

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John W. Ruchman

(Address)

634 Portland

15-

Filed....., 191

HARRY O. ANDREWS

Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Dec 28, 1914

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Shock & Exposure

CONTRIBUTORY

(Signed)

Dec 28, 1914

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

London 1914

Dec 30, 1914

UNDERTAKER

ADDRESS

Geo. Lindbergh 647 M. Pratt



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81465

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81465

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Keyworth Ave. 15- WARD)

2-FULL NAME

Alice Beatrice Bennett

(Residence in Baltimore: No. 2606 Keyworth Ave. St.; yrs. mos. 19 ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

body

6-DATE OF BIRTH

Dec 11 1914  
(Month) (Day) (Year)

7-AGE

19 yrs. mos. 19 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

Balto. Md.

10-NAME OF FATHER

Harry O Bennett

11-BIRTHPLACE OF FATHER  
(State or country)

Ba

12-MAIDEN NAME OF MOTHER

Edith M Miller

13-BIRTHPLACE OF MOTHER  
(State or country)

Ba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

H O Bennett  
(Informant)

2606 Keyworth Ave  
(Address)

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Dec 30 1914  
(Month) (Day) (Year)

11-HEREBY CERTIFY, That I attended deceased from Dec 11, 1914, to Dec 30, 1914,

that I saw him alive on Dec 30, 1914, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH\* was as follows:

Diphtheria

Contributory  
(SECONDARY)

Exhaustion

(Signed)

H. H. Hunt M. D.  
Dec 30, 1914 [Address] 1724 York Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.  
If not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grand Ridge Cw Dec 31 1914

17-UNDERTAKER

ADDRESS

Harry W. Ehlen W. North Ave

DEC 30 1914

HARRY G. ANDREWS,

Marial Permit Clerk

REGISTRAR



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81466

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 C81466

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE (NO.

ST.

10

WARD)

2-FULL NAME

Mary Flynn

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

6-DATE OF BIRTH

Unknown 1842

7-AGE

64

Yrs.

Mos.

Ds.

Or

Min?

If LESS than  
1 day, hrs.  
1 day, min?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE  
(State or country)

Ireland

10-NAME OF FATHER

Patrick Flynn

11-BIRTHPLACE OF FATHER  
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Hanna Black

13-BIRTHPLACE OF MOTHER  
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Rose

(Address) Little Sisters of the Poor

15-

DEC 30 1914

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Dec 28

(Month)

(Day)

1914

(Year)

17- I HEREBY CERTIFY That I attended deceased from

191

to

191

that I saw him alive on Dec 27 1914

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH\* was as follows:

Pneumo-pneumonia

5 days

(Duration)

Yrs.

Mos.

Ds.

Contributory  
(SECONDARY)

(Duration)

Yrs.

Mos.

Ds.

(Signed)

F. A. Warner

M. D.

Dec 29

1915

[Address]

1133 Valley St.

\* State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 2 yrs. 4 mos. 4 ds. In the State of Md. yrs. mos. ds.

Where was disease contracted, if not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral

Dec 31

1914

20-UNDERTAKER

ADDRESS

F. A. Krause

703 Hanover St.

C81467

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1101 Vine* ST. *18* WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2. FULL NAME

(Residence in Baltimore: No. *1101 Vine* St.: yrs. mos. *4* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3. SEX

*Female*

## 4. COLOR OR RACE

*Col*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

## 6. DATE OF BIRTH

*March 3, 1894*  
(Month) (Day) (Year)

## 7. AGE

*20* yrs. *9* mos. *25* ds.

If LESS than 1 day,  
... hrs. or ... min.

## 8. OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Genl Housework at home*

## 9. BIRTHPLACE, (State or Country)

*Baltimore Md*

## PARENTS.

## 10. NAME OF FATHER

*Wm H Robinson*

## 11. BIRTHPLACE OF FATHER (State or Country)

*Baltimore Md*

## 12. MAIDEN NAME OF MOTHER

*Mary*

## 13. BIRTHPLACE OF MOTHER (State or Country)

*Baltimore Md*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Wm H Robinson*  
*1101 Vine St*

15. DEC 30 1914

HARRY O. ANDREWS,

Filed..... 1914

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH

*Dec 28, 1914*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 24, 1914* to *Dec 28, 1914*, that I saw her alive on *Dec 28, 1914* and that death occurred, on the date stated above, at *6:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Inter Pneumonia*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*J. P. Haddock* M. D.*Dec 28, 1914* (Address) *117 N Carroll*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death • yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*McGlenburn Cemetery*

## DATE OF BURIAL

*Dec 29 1914*

## 20. UNDERTAKER

*Alfred J Ireland 4448 Salvage*

## ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43

C81468

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Residence in Baltimore: No.

St.: 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed (Write the word)

6 DATE OF BIRTH May 5, 1826 (Month) (Day) (Year)

7 AGE 88 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER William Geiger

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MARRIED NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (State or country) not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Muesse

(Address) 1801 N. Caroline St

15. HARRY O. ANDREWS,

DEC 30 1914

Funeral Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 30th, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1914, to Dec 30th, 1914, that I saw him alive on Dec 29th, 1914, and that death occurred, on the date stated above, at 2:50 p.m. The CAUSE OF DEATH\* was as follows: @

Stomach Cancer (Duration) 7 yrs. 6 mos. ds.

Contributory (SECONDARY) Stomach Cancer (Duration) 7 yrs. 6 mos. ds. (Address) 1001 E. Cay St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Green Mount Jan 1, 1915

20. UNDERTAKER J. B. Cook ADDRESS 1003 N. Baltimore St

C81469

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C81469

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 112 N Calhoun ST.; 19 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 18 E Belvidere Ave. St. yrs. mos. ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX, Female

4-COLOR OR RACE, White

SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

## 6-DATE OF BIRTH,

Dec 28th 1914 (Month) (Day) (Year)

## 7-AGE,

If LESS than 1 day, 1 hr. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER,

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. ...

(Address) 18 E Belvidere Ave.

15-

DEC 30 1914

HARRY O. ANDREWS,

Filed. 191... Partial Permit. Otter Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 28th 1914, to Dec 28th 1914, that I saw her alive on Dec 28th 1914, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signed) E. J. Mortimer M. D.

Dec 28th 1914 (Address) 530 N Fulton Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 In the State yrs. mos. dv.

Where was disease contracted, if not at place of death?

Former or usual residence 18 E Belvidere Ave.

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. Peter's Cemetery Dec 30, 1914

## 20-UNDERTAKER

## ADDRESS

Geo. A. Garbig Balt &amp; Payson Sts



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81470

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 515 Oxford 17

ST. WARD)

2-FULL NAME

Elinor Booz

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 515 Oxford

St. 50 yrs. mon. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX 4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

Leutcuoun, 1863 (Month) (Day) (Year)

7-AGE

52 yrs. mos. ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Cook

9 BIRTHPLACE (State or country)

Chestertown Md

10 NAME OF FATHER

Osiah Booz

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Caroline Hensley

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deane Booz

(Address)

515 Oxford St

15

DEC 30 1914

Filed

191

HARRY O. ANDREWS, REGISTRAR

Marial Per... aut.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 27, 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about Aug 1, 1914, to Dec 27, 1914.

that I saw her alive on Dec 26, 1914.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Coronary of Artery

Personal knowledge (Duration) yrs. 3 mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. W. H. Hensley M. D.

Dec 28, 1914 (Address) 70 W. N. Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

12/31, 1914

20-UNDERTAKER

ADDRESS

Samuel L. Hensley

578 W. 2nd St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81471

## CERTIFICATE OF DEATH.

C81471

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1113 N. Bradford St.* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

## 6-DATE OF BIRTH,

*Unknown, 1855*  
(Month) (Day) (Year)

## 7-AGE,

*59* yrs. mos. ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*

## 9-BIRTHPLACE, (State or Country),

*Ireland*

## 10-NAME OF FATHER,

*James Gargan*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Mary Mead*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John J. Hara*(Address) *1113 N. Bradford St.*

## 15-

DEC 30 1914 HARRY O. ANDREWS,  
Filed... 191... Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*December 28, 1914*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec. 28, 1914, to Dec. 28, 1914,*that I saw her alive on *Dec. 28, 1914,*and that death occurred, on the date stated above, at *11A m.*

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. B. Levine* M. D.191... (Address) *Hebrew Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State ? yrs. mos. ds.

Where was disease contracted, if not at place of death? *1113 N. Bradford St.*Former or usual residence *1113 N. Bradford St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Nash, Conn.*

## DATE OF BURIAL,

*Dec. 31, 1914*

## 20-UNDERTAKER

*W. J. Schaeffer, Sr. 8 S. Front St.*

## ADDRESS

Print statement of OCCUPA-  
state CAUSE OF DEATH in plain terms, so that it may be properly classified.  
TION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Salmon Hooker Hospital ST. 7 WARD)

2-FULL NAME

Frank H. Morris

Residence in Baltimore: No.

Vincent Ohio

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

December 29

1881

1881

7-AGE

33

yrs.

mos.

ds.

If LESS than

1 day, hrs.

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Stationary Engineer

9-BIRTHPLACE

(State or country)

Ohio

United States

10-NAME OF FATHER

Amber

11-BIRTHPLACE OF FATHER

(State or country)

Amber

12-MAIDEN NAME OF MOTHER

Amber

13-BIRTHPLACE OF MOTHER

(State or country)

Amber

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles B. Thompson

(Address) Salmon Hooker Hospital

15-

DEC 30 1914

191

Marial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

December

29

1914

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec. 21, 1914, to Dec. 29, 1914,

that I saw him alive on Dec. 29, 1914,

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH\* was as follows:

marasmus

(Duration)

yrs.

mos.

3 weeks

Contributory (SECONDARY)

Pneumonia

(Duration)

yrs.

mos.

9 mos.

(Signed), Charles B. Thompson M. D.

December 29, 1914 [Address] Salmon Hooker Hospital

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. 8 ds. In the State, yrs. mos. 8 ds.

Where was disease contracted, If not at place of death? Vincent, Ohio

Former or usual residence Vincent, Ohio

19-PLACE OF BURIAL OR REMOVAL

Vincent Ohio

DATE OF BURIAL

Dec 31, 1914

20-UNDERTAKER

Arthur C. Fuller

ADDRESS

221 N Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81473

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81473

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

\*The CAUSE OF DEATH\* was as follows:

Remittent Fever + Bronchitis

Contributory (SECONDARY)

(Signed), M. D.

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

DEC 30 1914

HARRY O. ANDREWS,  
Marial Permit Clerk

REGISTRAR

FOUNDER

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81474

## CERTIFICATE OF DEATH.

28

C81474

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.:

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Frederick Thackerington* *626 N. Calvert St.* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *?*

6-DATE OF BIRTH *Unknown* (Month) (Day) (Year)

7-AGE, *49* yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Salesman*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *"*

12-MAIDEN NAME OF MOTHER *"*

13-BIRTHPLACE OF MOTHER (State or Country), *"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mercy Hospital*(Address) *626 N. Calvert St.*15- *DEC 30 1914* HARRY O. ANDREWS,Filed *DEC 30 1914* Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec 29 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 21 1914*, to *Dec 29 1914*, that I saw him alive on *Dec 29 1914*, and that death occurred, on the date stated above, at *9:10 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
(Duration) *Do not know*  
CONTRIBUTORY *Do not know*  
(Secondary) *Do not know*  
(Duration) *Do not know*  
(Signed) *Edward P. Smith, M.D.*  
*Dec 30 1914* (Address) *Mercy Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the *20* yrs. mos. ds. State

Where was disease contracted, if not at place of death? *Do not know*

Former or usual residence *626 N. Calvert St.*

19-PLACE OF BURIAL OR REMOVAL, *COLLEGE OF P. & S.* DATE OF BURIAL, *DEC 8 1914*

Address *Corner of P. & S. Health,*

Reg. Wm. E. WOODALL

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly translated. List statement of occupation in every important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—200 Bks.

C81475

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 North Calhoun St.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy C. Hughes

(Residence in Baltimore: No. 528 North Calhoun St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)

6-DATE OF BIRTH, unknown, 1851 (Month) (Day) (Year)

7-AGE, 63 yrs. = mos. = da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, John Claypoole

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel I. Davis

(Address) 528 N. Calhoun Street

15- DEC 30 1914 HENRY O. ANDREWS, Registrar.

Filed, 1914 Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29th, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 29th, 1914, to Dec. 28th, 1914, that I saw her alive on December 28th, 1914, and that death occurred, on the date stated above, at 5, 15<sup>4</sup> m. The CAUSE OF DEATH\* was as follows:

Hypostatic Pneumonia

(Duration) 7 yrs. 7 mos. 21 da.

CONTRIBUTORY Sciatica (Secondary)

(Duration) 7 yrs. 6 mos. da.

(Signed) O. Newell Dennis, M. D. Dec. 29th, 1914 (Address) #1317 N. Fulton Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount DATE OF BURIAL, Dec. 31, 1914

20-UNDERTAKER, E. M. Mitchell ADDRESS, 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81476

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81476

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Mt. Royal Ave. ST. 14 WARD)

2-FULL NAME

Frank Van New Kirk

(Residence in Baltimore: No. 1526 Mt. Royal Ave.

St. 43 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Oct. 16, 1871  
(Month) (Day) (Year)

7-AGE

43 yrs. 2 mos. 12 ds. or 1 day, 0 hrs., 0 min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Piano Business (Retail)

9-BIRTHPLACE  
(State or country)

Baltimore, Md.

PARENTS

10-NAME OF FATHER

Joseph Van New Kirk

11-BIRTHPLACE OF FATHER  
(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Sarah

13-BIRTHPLACE OF MOTHER  
(State or country)

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Elizabeth Van New Kirk

(Address)

1526 Mt. Royal Ave.

15-

DEC 30 1914

Filed

191

Barial Permit Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

December 28, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 1914, to, December 28, 1914, that I saw him alive on December 28, 1914, and that death occurred, on the date stated above, at 9:17 m.

The CAUSE OF DEATH\* was as follows:

Facial Erysipelas

(Duration) 4 yrs. 0 mos. 0 ds.

Contributory (SECONDARY)

Chronic Nephritis

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed)

Julius Friedlander

M. D.

Dec 29, 1914. [Address] 1013 N. Charles

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

Dec. 30, 1914

20-UNDERTAKER

Henry W. Means & Son

ADDRESS

805 N. Calvert St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81477

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81477

PLACE OF DEATH 1920 Elm St

REGISTERED NO. C

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

Sigga Lucia Pionti  
1920 Elm St

St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED

Female White

Single

6 DATE OF BIRTH

12 18, 1914

7 AGE

10 yrs. 10 mos. 11 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Baltimore

10 NAME OF FATHER

Carlo Pionti

11 BIRTHPLACE OF FATHER

Italy

12 MAIDEN NAME OF MOTHER

Rosina Scartanoz

13 BIRTHPLACE OF MOTHER

Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Pionti

(Address)

213 W. 23rd St

15

DEC 30 1914

HARRY O. ANDERSON,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12 29, 1914

17 I HEREBY CERTIFY, That I attended deceased from

Dec 27, 1914, to Dec 29, 1914.

that I saw her alive on Dec 28, 1914.

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH was as follows:

Aethemia

Contributory (SECONDARY)

Septicemia

(Signed)

Mathew Winters

M. D.

Dec 29, 1914. (Address) 3304 Mulbrook Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Dec 30, 1914

20 UNDERTAKER

E. M. Mitchell

ADDRESS

120 W. Fayette



## C81478 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 512. S. Bond Str,

ST. 3

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Thadeus Ekielski,

(Residence in Baltimore: No. 512. S. Bond Str.

St.; 1 yrs. 5 mos. 20 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH,

July (Month)

5 (Day)

1913 (Year)

7-AGE,

1

5

20

If LESS than 1 day,

yrs. mos. da.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work,

Infant

(b) General nature of industry, business, or establishment in which employed (or employer),

None

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Felix Ekielski

11-BIRTHPLACE OF FATHER

(State or Country),

Russian Poland

12-MAIDEN NAME OF MOTHER

Frances Glowinkowski

13-BIRTHPLACE OF MOTHER

(State or Country),

Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Ekielski,

512. S. Bond Str,

(Address)

15-

DEC 30 1914

Filed

191

BERRY O. ANDREWS,

Bureau of Health

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

12

29

1914

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

26th

1914, to

29th

1914,

that I saw him alive on December 29th 1914,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. da.

(Signed)

J. A. Rutledge

M. D.

(Address) 100 S. Jackson St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Dec 31, 1914

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern

AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81479

## CERTIFICATE OF DEATH

C81479

## 1-PLACE OF DEATH

CITY OF BALTIMORE:

(No. 518 Cathedral

ST. 11 WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Olivia Bringle Shriver

(Residence in Baltimore: No. 518 Cathedral

St. 85 yrs. 2 mos. 5 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(If write the word?)

widowed

## 6-DATE OF BIRTH

October

24

1829

(Month)

(Day)

(Year)

## 7-AGE

85

yrs.

2

mos.

5

da.

If LESS than 1 day:

hrs.

or

min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Mother

## 9-BIRTHPLACE,

(State or Country)

Frederick Maryland

## 10-NAME OF FATHER

Lawrence J. Bringle

## 11-BIRTHPLACE OF FATHER

(State or Country) Frederick Md.

## 12-MAIDEN NAME OF MOTHER

Catherine C. Shriver

## 13-BIRTHPLACE OF MOTHER

(State or Country) Frederick Co. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Alexis Shriver

(Address)

Bel Air Md.

## 15-

DEC 30 1914

HARRY O. ANDERSON

Filed

191

Burial Permit 019

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16-DATE OF DEATH

December 29

(Month)

(Day)

1914

(Year)

I HEREBY CERTIFY That I attended deceased from

Dec 24 1914

to Dec 29

1914

that I saw him alive on

Dec 27

1914

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH was as follows:

(Acute) Labor Pneumonia

(Duration)

yrs.

mos.

4

## CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

da.

(Signed)

J. H. M. M. D.

1914

(Address)

14 N. B. Rd. N.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Greenmount Cem.

## DATE OF BURIAL

Dec 31, 1914

## 20-UNDERTAKER

Henry H. Gutierrez &amp; Co. Richard M. Kelly

## ADDRESS

14 N. B. Rd. N.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81480

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81480

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2211 Preston Place* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Patrick Harrigan*(Residence in Baltimore: No. *2211 Preston Place* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Feb 17th, 1860*

(Month)

(Day)

(Year)

7-AGE, *54* yrs. *10* mos. *22* ds.

If LESS than 1 day, hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Retired Soldier*(b) General nature of industry, business, or establishment in which employed (or employer), *U. S. Army*9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martha Harrigan*(Address) *2211 Preston Place*

## 15-

Filed

191

HARRY O. ANDERSON

Marital Permit Office

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Dec 29th, 1914*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 25* 191*4*, to *Dec 29* 191*4*, that I saw him alive on *Dec 29* 191*4*, and that death occurred, on the date stated above, at *1.250* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of Liver*  
*Diagnosis*  
 (Duration) *6* yrs. *6* mos. *6* ds.

## CONTRIBUTORY (Secondary)

(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *Emil Novak* M. D.*Dec 30*, 191*4* (Address) *823 N. Pennsylvania*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Old Point Comfort*DATE OF BURIAL, *Dec 31, 1914*20-UNDERTAKER *John A. Moran*ADDRESS *Bank*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81481

## CERTIFICATE OF DEATH.

28

C81481

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *3* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *522 S. Caroline St* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*male*

## 4-COLOR OR RACE

*black*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*widower*

## 6-DATE OF BIRTH

*Unknown*, 19*01*  
(Month) (Day) (Year)

## 7-AGE

*33* yrs. mos. ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer).*Farmer*

## 9-BIRTHPLACE, (State or Country),

*Baltimore*

## 10-NAME OF FATHER

*Unknown*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ananda Price*  
(Address) *522 S. Caroline St.*15-DEC 30 1914  
Filed *ROBERT KRAUTER*  
Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*December 26*, 19*14*.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 24* 191*4*, to *Dec 26* 191*4*, that I saw him alive on *Dec 26* 191*4*, and that death occurred, on the date stated above, at *12 noon* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*CONTRIBUTORY *Chronic Nephritis & Arteriosclerosis*  
(Secondary) (Duration) *unknown* yrs. mos. ds.(Signed) *J. D. Vinton, C. C. A.* M. D.  
*Dec 26*, 191*4* (Address) *St Joseph's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *3* ds. State yrs. mos. ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *522 S. Caroline St.*

## 19-PLACE OF BURIAL OR REMOVAL

*Seabury Cem*

## DATE OF BURIAL

*Dec 27*, 191*4*

## 20-UNDERTAKEN

*Harry A. Godery* 1728 Orleans St.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81482

28

C81482

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* REGISTERED NO. C  
 CITY OF BALTIMORE: (No. *17* ST.; *17* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
 2-FULL NAME *William A. Helker*  
 (Residence in Baltimore: No. *408 N. Paca St.* St. *59* yrs., *0* mos., *24* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widower*  
 6-DATE OF BIRTH, *Sept 6, 1855*  
 (Month) (Day) (Year)  
 7-AGE, *59* yrs., *3* mos., *24* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work. *Laborer*  
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.  
 10-NAME OF FATHER, *Jacob Helker*  
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*  
 12-MAIDEN NAME OF MOTHER *Unknown*  
 13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
 (Informant) *Wm A. Helker*  
 (Address) *408 N. Paca St.*

15-DEC 30 1914 ROBERT KRAUTER,  
 Filed..... 191... Burial Permit Clerk  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *12-30-1914*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *12-16-1914*, to *12-30-1914*, that I saw him alive on *12-30-1914*, and that death occurred, on the date stated above, at *10:45* a.m.  
 The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
 (Duration) .... yrs. .... mos. .... ds.  
 CONTRIBUTORY *Laryngeal Tuberculosis*  
 (Secondary)  
 (Duration) .... yrs. .... mos. .... ds.  
 (Signed) *Alkausembock P. D. M. D.*  
*12-30-1914* (Address) *University Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. *15* ds. In the State *59* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *408 N. Paca St.*

19-PLACE OF BURIAL OR REMOVAL, *Western* DATE OF BURIAL *Jan 1, 1915*

20-UNDERTAKER *Forstner* ADDRESS *1003 7th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081483

HEALTH DEPARTMENT—CITY OF BALTIMORE

081483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 376 Lewis

ST. 5 WARD)

REGISTERED NO. C

2-FULL NAME

Wm A Blackens

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 376 Lewis

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)

Widowed

6-DATE OF BIRTH,

May 13<sup>th</sup>, 1868

7-AGE,

47 yrs. 7 mos. 13 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Junx Dealer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

MD

PARENTS.

10-NAME OF FATHER,

Andrew Blackens

11-BIRTHPLACE OF FATHER  
(State or Country),

MD

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jones

(Address) 612 Calver St.

15-

DEC 30 1914

ROBERT J. KRAUTER,

Marial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 28<sup>th</sup>, 1914

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Oleg J. Russell, M. D.

(Coroner.)  
Dec 29<sup>th</sup>, 1914 (Address) 423 N. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Asbury Cemetery Dec 31, 1914

20-UNDERTAKER

ADDRESS

R. E. Gross 1405 Mcelderry St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

C81484

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

50

81484

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

68 S Carrollton ave

18

WARD)

FULL NAME

Ellen Kelly

Residence in Baltimore: No.

68 S Carrollton av

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widowed

6 DATE OF BIRTH

June 28, 1848

7 AGE

66 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE  
(State or country)

Ireland

10 NAME OF FATHER

John Carroll

11 BIRTHPLACE OF FATHER  
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget Woodlock

13 BIRTHPLACE OF MOTHER  
(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Grady

(Address)

68 S Carrollton av

15.

DEC 30 1914

DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 28, 1915

I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1915, to Jan 28, 1915.

that I saw him alive on Jan 26, 1915.

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH\* was as follows:

Asphyxia

Contributory  
(SECONDARY)

Diabetes (Duration) yrs. 3 mos. ds.

(Signed)

H. J. May M. D.  
1746 Carey

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

St Patrick am

DATE OF BURIAL

Jan 31, 1915

20 UNDERTAKER

John J Fields 1200 Lombard st



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81485

## CERTIFICATE OF DEATH.

79

C81485

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1427 Mc Eldeny* ST.: *5* WARD)2-FULL NAME *Sophia Zuck*(Residence in Baltimore: No. *1427 Mc Eldeny* St.: ..... yrs. .... mos. .... ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Col.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*  
(Write the word.)6-DATE OF BIRTH, *Unknown* 18*49*

(Month) (Day) (Year)

7-AGE, *65?*

..... yrs. .... mos. .... da.

If LESS than 1 day,  
..... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *General*(b) General nature of industry, business, or establishment in which employed (or employer), *domestic*9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena Franklin*(Address) *1427 Mc Eldeny*

15-

Filed.....

191

ROBERT KRAUTER,  
Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec. 29*, 191*4*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 12*, 191*4*, to *Dec. 29*, 191*4*, that I saw her alive on *Dec. 28*, 191*4*, and that death occurred, on the date stated above, at *6 p. m.* The CAUSE OF DEATH\* was as follows:  
*Mitral regurgitation*  
*(First Compensation)*

(Duration)..... yrs. .... mos. .... da.

CONTRIBUTORY (Secondary) *Infantile Pige*

(Duration)..... yrs. .... mos. .... da.

(Signed)..... M. D.

(Address) *611 N. Calhoun*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... da. In the State ..... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Green Gown*DATE OF BURIAL, *Dec 31*, 191*4*

20-UNDERTAKER

ADDRESS

*Sam H. Chase & Son 4007 Mosher*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81486

C81486

## CERTIFICATE OF DEATH.

28 REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 E. Chase

ST.; 9<sup>th</sup> WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel E. Chenoweth

(Residence in Baltimore: No. 1909 E. Chase

St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 8, 1868

(Month)

(Day)

(Year)

7-AGE,

46 yrs. 9 mos. 20 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Huckster

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Calvert Co. Md.

10-NAME OF FATHER,

Wm. Chenoweth

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella Chenoweth

(Address) 1909 E. Chase St.

15-

DEC 30 1914

ROBERT KRAUTER,

101 Barial Parale Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

December 28, 1914.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 20, 1914, to Dec. 28, 1914,

that I saw him alive on Dec. 25, 1914,

and that death occurred, on the date stated above, at 1<sup>15</sup> P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Fenty, M. D.

Dec. 28, 1914 (Address) 223 N. Caroline St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

Dec. 31, 1914

20-UNDERTAKER

ADDRESS

Henry Lutz

1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81487

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

168

C81487

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

## 2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

## 6-DATE OF BIRTH.

Month Day Year

## 7-AGE,

ab. 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. clerk  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

New York

## 10-NAME OF FATHER,

unknown

## 11-BIRTHPLACE OF FATHER (State or Country),

unknown

## 12-MAIDEN NAME OF MOTHER

unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

DEC 30 1914

ROBERT L. KRAUTER

Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 10-DATE OF DEATH,

December 28, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Asphyxia from Carbon dioxide and illuminating gas.  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. M. Savage, M. D.  
(Coroner)

Dec 30, 1914 (Address) 1729 Madison Ave

\*State the DISEASE CAUSING DEATH or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

110 W. Mulberry St.

Former or usual residence 110 W. Mulberry St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Rochelle, N.Y. Dec 30 1914

20-UNDERTAKER ADDRESS

G. F. Walker 223 W. Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81488

## CERTIFICATE OF DEATH.

64 C81488

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 Hollins ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. 1318 HollinsSt.; 76 yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

July 15, 1838  
(Month) (Day) (Year)

## 7-AGE,

76 yrs. — mos. — ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Stationary  
(b) General nature of industry, business, or establishment in which employed (or employer). Engineer

## 9-BIRTHPLACE, (State or Country),

Baltimore, Md

## PARENTS.

## 10-NAME OF FATHER,

Henry Webster

## 11-BIRTHPLACE OF FATHER (State or Country),

Dorchester Co Md

## 12-MAIDEN NAME OF MOTHER

Ann Lewis

## 13-BIRTHPLACE OF MOTHER (State or Country),

Annapolis Co Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. W. Webster Jr.(Address) 1318 Hollins St

## 15-

DEC 30 1914

Filed

ROBERT A. KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

December 29, 1914  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from August 15 1914, to Dec. 29 1914, that I saw him alive on Dec. 29 1914, and that death occurred, on the date stated above, at 2.15 m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(Duration) .... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) J. C. Bond M. D.Dec. 29, 1914. (Address) 1302 W. Lombard St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

London Park Cem.

## DATE OF BURIAL,

Jan. 1st, 1915

## 20-UNDERTAKER

Robt Brooks Son & Co

## ADDRESS

3 E. Calhoun & Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81489

C81489

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Wilkens Ave. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2408 Wilkens AveSt.; 1 yrs., 1 mos. 4 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

female

## 4-COLOR OR RACE,

white

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

11 17, 1913  
(Month) (Day) (Year)

## 7-AGE,

1 yrs., 1 mos., 12 ds.

## If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,  
(State or Country),Balto. Md

## PARENTS.

## 10-NAME OF FATHER,

Wilton R. Jefferson11-BIRTHPLACE OF FATHER  
(State or Country),Balto City

## 12-MAIDEN NAME OF MOTHER

Rosalee McCabe13-BIRTHPLACE OF MOTHER  
(State or Country),Balto. Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Wilton R. Jefferson

(Address).....

2408 Wilkens Ave

## 15-

Filed DEC 30 1914

ROBERT J. KRAUTH

Burial Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

12 29, 1914  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

12-26 1914, to 12-29 1914,that I saw her alive on 12-29 1914,and that death occurred, on the date stated above, at 10 a m.

## The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia  
10 days.(Duration) X yrs. X mos. 10 ds.CONTRIBUTORY  
(Secondary)Exhaustion(Duration) X yrs. X mos. 1 ds.

## (Signed).....

P. B. Bullock M. D.12/30 1914 (Address) 1939 Wilkens

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Western CemeteryDec. 30., 1914

## 20-UNDERTAKER

## ADDRESS

Robert Brinkson CoBaltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81490

## CERTIFICATE OF DEATH.

89

C81490

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 E. St. ST.: 10 WARD)

## 2-FULL NAME

Residence in Baltimore: No. 941 E. St. St.: \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Nov. 2, 1914  
(Month) (Day) (Year)

7-AGE,

1 mos. 26 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto Md

PARENTS.

10-NAME OF FATHER,

Harry R. Nyce

11-BIRTHPLACE OF FATHER (State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Annie Stockman

13-BIRTHPLACE OF MOTHER (State or Country),

New Orleans

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Harry R. Nyce

(Address).

941 E. St.

15-

DEC 31 1914

HARRY O. ANDREWS,

Filed \_\_\_\_\_, 191\_\_\_\_. Serial Permt. Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 30, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 29, 1914, to Dec 30, 1914,that I saw h\_\_\_\_\_ alive on Dec 30, 1914,and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

Dec 30, 1914 (Address) 16 E. Bond St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19-PLACE OF BURIAL OR REMOVAL,

Landon Park

DATE OF BURIAL,

Dec 31, 1914

20-UNDERTAKER

Robt J. Turner

ADDRESS

1442 N. Broadway

Every statement of fact statement of OCCUPATION is very important. See instructions on back of certificate.

C81491

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

79 C81491  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S. Monroe ST.; 19 WARD)

## 2-FULL NAME

Residence in Baltimore: No. 603 S. Monroe

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; — yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

## 5-SINGLE, MARRIED, WIDOWED.

Widowed

(Write the word.)

## 6-DATE OF BIRTH.

April 23, 1845

(Month)

(Day)

(Year)

## 7-AGE.

69 yrs., 8 mos., 8 ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9-BIRTHPLACE.  
(State or Country).

Germany

## 10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER  
(State or Country).

Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country).

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mr. Christina Williams  
603 S. Monroe St.

15

DEC 31 1914

HARRY C. ANDREWS,

191. Serial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Dec 31, 1914

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20, 1914, to Dec 31, 1914.

that I saw him alive on Dec 29, 1914, and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH\* was as follows:

Coronary Aneurysm

(Duration) 10 yrs., 10 mos., 10 ds.

CONTRIBUTORY  
(Secondary)

Myocarditis

(Duration) 2 yrs., 10 mos., 10 ds.

(Signed) E. J. [Signature] M. D.

1914, 1914 (Address) 24 W. [Signature]

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Western Cemetery

## DATE OF BURIAL.

Jan 7, 1915

## 20-UNDERTAKER

Joseph B. Cook

## ADDRESS

1002 N. Latta

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81492

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

DEC 31 1914

BARRY O. ANDERSON,

Barial Permit Clerk

Registrar.

ST.

WARD)

79  
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 32 yrs., mos. ds.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY That I took charge of the remains described above, held in inquiry, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry, (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81493

## CERTIFICATE OF DEATH.

REGISTERED NO. C

33 C81493

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

## FULL NAME

(Residence in Baltimore: No

St.; - yrs. - mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

7-AGE.

IF LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

9-BIRTHPLACE.

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

DEC 31 1914

HARRY O. ANDERSON

Filed.

101.

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Dec 20, 1914.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 29, 1914, to Dec 30, 1914, that I saw him alive on Dec 30, 1914, and that death occurred, on the date stated above, at 8 - P. M.

The CAUSE OF DEATH\* was as follows:

Tuberculous sarcoidiasis joint (right).

(Duration) 2 yrs. - mos. - ds.

CONTRIBUTORY Post-operative shock (Secondary)

(Duration) 2 hrs. - mos. - ds.

(Signed) J. Polim &amp; Davis M. D.

101... (Address) U. P. S.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. - mos. - ds. 2 ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

Yokum, Texas

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Yokum, Texas

Dec 31, 1914

20-UNDERTAKER

ADDRESS

Joseph S. Cook

1003 N. Lulu St.

N.B.--Every item of information shown on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81494

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81494

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

FULL NAME

Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

1-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

DEC 31 1914

HARRY O. ANDREWS

Filed, 191

Burial Permit 01

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

May 1914, to Dec. 29, 1914.

that I saw him alive on December 28, 1914.

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

Duration about eight mos.

Contributory (SECONDARY)

(Signed) Dr. P. Lockwood M. D.

Dec. 30, 1914 (Address) 8 E. Eager St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Garison Trust Dec 31, 1914

Chas. E. Branch 802 Madison Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

79  
C81495  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 528 W Lee St

ST.: 22 WARD)

2-FULL NAME Kesiiah Anthony

(Residence in Baltimore: No. 528 W Lee St

51 yrs., mos. ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)

6-DATE OF BIRTH, Nov 1, 1863 (Month) (Day) (Year)

7-AGE, 51 yrs., mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER, Thomas Horrod

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Betsie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Jefferson

(Address) 305 W Preston St

DEC 31 1914

HARRY O. ANDREWS

Filed 1914 Marial Permit/C

Registrar

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1914 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.)

Inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Valvular Disease fo Heart

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Dec 30, 1914 (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in Deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

In the yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Place of usual residence

PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

UNDERTAKER, ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81496

HEALTH DEPARTMENT—CITY OF BALTIMORE

350  
153 C81496

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1413 Ward

St. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME John Augustus

(Residence in Baltimore: No. 1413 Ward

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH,

Dec 23rd, 1914  
(Month) (Day) (Year)

7-AGE,

7 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

Balto. Md.

PARENTS.

10-NAME OF FATHER,

John C. Augustus

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Viola Young

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Young

(Address) 1413 Ward St.

15 DEC 31 1914

HARRY O. ANDREWS,

Filed 1914 Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 30th, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Lack of care  
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Saml. H. ... M. D.  
(Coroner)  
1914 (Address) 502 Madison St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn Cem.

Dec 31, 1914

20-UNDERTAKER

ADDRESS

John J. ...

1426 ...

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81497

## CERTIFICATE OF DEATH.

92

C81497

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Port

ST.: 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mary L. Finn

(Residence in Baltimore: No. 1726 Port

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-STATUS,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Widow

## 6-DATE OF BIRTH

August 15th, 1869  
(Month) (Day) (Year)

## 7-AGE

45 yrs. 4 mos. 15 ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Baltimore

## 10-NAME OF FATHER

James Prager

11-BIRTHPLACE OF FATHER  
(State or Country)

Baltimore

## 12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stockman

(Address) 1713 Port St.

## 15-

Filed

DEC 31 1914

HARRY O. ANDREWS

Burial Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Dec 30, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22, 1914, to Dec 30, 1914, that I saw her alive on Dec 29, 1914, and that death occurred, on the date stated above, at 2:00 a.m. The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Herman M. C. Parker, M. D.

Dec 30, 1914. (Address) 1051 Lexington St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Holy Cross Cemetery Jan. 2, 1915

## 20-UNDERTAKER

## ADDRESS

R. C. Wadefield 914 Sprague Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81498

## CERTIFICATE OF DEATH.

42  
REGISTERED NO. C

C81498

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Sterling ST.; 5 WARD)

## 2-FULL NAME

Mary E. Washington  
(Residence in Baltimore; No. 610 Sterling St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)  
Married

## 6-DATE OF BIRTH

Aug. 28, 1894  
(Month) (Day) (Year)

## 7-AGE

40 yrs. 4 mos. 2 ds. If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
Laundress9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

DEC 31 1914  
Filed.....  
HARRY O. ANDREWS,  
Bureau Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Dec. 30, 1914  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct. 3 1914, to Dec. 30 1914, that I saw him alive on Dec. 24 1914, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cancer of the Uterus  
(Duration).....yrs. 4 mos. ....ds.CONTRIBUTORY  
(Secondary)(Signed).....E. B. Miller M. D.  
Dec 30, 1914 (Address).....610 Sterling St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. ....mos. ....ds. In the State.....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mt. Zion Cemetery Jan. 1, 1915

## 20-UNDERTAKER

## ADDRESS

Robert A. Elliott 506.1 Rogers Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

C81499

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1407 Q. Fulton Ave. ST. 15

WARD)

2-FULL NAME

Mary Ellen Phillips

(If death occurred in a hospital or institution, give its NAME instead of street and number and IN out No. 18.)

(Residence in Baltimore: No. 1407 Q. Fulton Ave St. - yrs. 5 mos. - ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

single

6-DATE OF BIRTH

April

(Month)

30

(Day)

1914

(Year)

7-AGE

8

mos.

1 day,

hrs.

min.?

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE

(State or country)

South Carolina

10-NAME OF FATHER

James T Phillips

11-BIRTHPLACE OF FATHER

(State or country)

Richell R. Co.

12-MAIDEN NAME OF MOTHER

Willie Hilfiker

13-BIRTHPLACE OF MOTHER

(State or country)

Texas

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willie Phillips

(Address)

1407 Q. Fulton Ave

15-

DEC 31 1914

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Dec

(Month)

30

(Day)

1914

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

30

, 191

to,

191

that I saw h. n. alive on

Dec 30 12:00 PM 1914

and that death occurred, on the date stated above, at 9:50 am.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Broncho)

Contributory (SECONDARY)

(Duration)

yrs

mos.

8

ds.

(Signed),

Dr. J. Thomas Nelson

Dec 30

, 1914

[Address]

1407 Q. Fulton Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

...yrs...

...mos...

...ds.

in the

State

...yrs...

...mos...

...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Peters

Jan 1

1915

20-UNDERTAKER

ADDRESS

Joseph S. S. 1600 W North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81500

## CERTIFICATE OF DEATH

92 C81500  
REGISTERED NO. C.....

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *746 Raborg St.* ST. *4* WARD)

### 2-FULL NAME

(Residence in Baltimore: No. *746 Raborg St.* St. *34* yrs. *3* mos. *12* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3-SEX

*Female*

#### 4-COLOR OR RACE

*Black*

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

*Single*

#### 6-DATE OF BIRTH

*Sept 7*, 1883  
(Month) (Day) (Year)

#### 7-AGE

*31* yrs. *3* mos. *12* ds. or min.?  
If LESS than 1 day, hrs., min.?

#### 8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Domestic*

#### 9-BIRTHPLACE (State or country)

*Baltimore City*

### PARENTS

#### 10-NAME OF FATHER

*Geo A. Milburn*

#### 11-BIRTHPLACE OF FATHER (State or country)

*Baltimore City*

#### 12-MAIDEN NAME OF MOTHER

*Adonia Thompson*

#### 13-BIRTHPLACE OF MOTHER (State or country)

*Baltimore City*

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Alberta Williams*

*746 Raborg*

#### 15-

DEC 31 1914  
Filed 191

HARRY O. ANDERSON,  
Burial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

#### 16-DATE OF DEATH

*Dec 29*, 191*4*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 20*, 191*4*, to, *Dec 29*, 191*4*, that I saw h..... alive on *Dec 28*, 191*4*, and that death occurred, on the date stated above, at *3 A* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

#### Contributory (SECONDARY)

*Pneumonia* (Duration) *6* mos. ds.  
*For some*  
*J. J. Norwood* (Signed), *2* yrs. mos. ds.  
*Dec 29*, 191*4* [Address] *939 W. Fayette St.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

#### 19-PLACE OF BURIAL OR REMOVAL

*Mt. Auburn Cem.*

#### DATE OF BURIAL

*Dec 31*, 191*4*

#### 20-UNDERTAKER

*Geo. H. Holland*

#### ADDRESS

*577 Robert St.*









## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81503

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81503

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 E. Balto. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Lilbie SussmanResidence in Baltimore: No. 2023 E. Baltimore St.; 22 yrs., — mos., — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White5-SINGLE,  
MARRIED, Widow,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

Unknown  
(Month) (Day) (Year)

## 7-AGE,

46 yrs., — mos., — ds.

10 LESS than 1 day.

— hrs. or — min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....None9-BIRTHPLACE,  
(State or Country),Russia

## PARENTS.

## 10-NAME OF FATHER,

Jacob Kimmel

## 11-BIRTHPLACE OF FATHER

(State or Country),

Russia

## 12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER  
(State or Country),Russia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. M. Sussman

(Address)

2023 E Balto St

## 15-

DEC 31 1914

HARRY O. ANDREWS,

Berial Permit Clerk

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 30, 1914  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1914, to Dec 30, 1914, that I saw him alive on Dec 30, 1914 and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH\* was as follows:

Fall down stairs  
Concussion of brain  
Caused by accident  
Complicated by laceration of scalp  
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY  
(Secondary)Cardiac asthma  
(Duration)..... yrs..... mos..... ds.(Signed) G. E. Ruse M. D.Dec 31, 1914 (Address) 2023 E Balto St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2023 E Balto St

## 19-PLACE OF BURIAL, OR REMOVAL,

## DATE OF BURIAL,

Hebrew Home for the AgedDec 31, 1914

## 20-UNDERTAKER

ADDRESS 1107 EJ. R. RuseBalto

N.B.—Every item of information entered on this certificate is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81504

103 C81504

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Chase

ST. 8 WARD)

REGISTERED NO. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Ida M. Laddon

(Residence in Baltimore: No. 1610 E. Chase

St.; 61 yrs., mos. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

## 6-DATE OF BIRTH,

December 12th, 1853

(Month)

(Day)

(Year)

## 7-AGE,

61 yrs. 19 mos. 19 da.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Manhattan Island N.Y.

## 10-NAME OF FATHER,

Greenbury Ballouay

11-BIRTHPLACE OF FATHER  
(State or Country),

Unknown

## 12-MAIDEN NAME OF MOTHER

Katherine Leachke

13-BIRTHPLACE OF MOTHER  
(State or Country),

St. Michael

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Seddon

(Address) 1610 E. Chase St.

## 15-

Filed DEC 31 1914

Barial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

December 29th, 1914

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec. 7, 1914, to Dec. 29, 1914,

that I saw her alive on Dec. 27, 1914,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Gastritis

(Duration) yrs. mos. 22 da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed) William H. Johnson M. D.

Dec. 29, 1914 (Address) 2017 E. Ballou St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Sondan Park

## DATE OF BURIAL,

Dec. 31, 1914

## 20-UNDERTAKER

C. M. Underwood 1610 E. Chase St.

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

64 C81505

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 68 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARKED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 31 1914

Filed

HARRY O. ANDREWS,

Burial Permit Officer

REGISTRAR

Baltimore County Jan 1, 1915

Mrs A Rohde Son 730 Park Ave



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—5-19-13—M. & T.—500 Bks.

081506

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

28

081506

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 S. Carey ST.)

REGISTERED NO. C

### 2-FULL NAME

Bertha Roseway

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1232 S. Carey St.)

St.; 32 yrs., mos. da.

### PERSONAL AND STATISTICAL PARTICULARS.

#### 2-SEX.

Female

#### 4-COLOR OR RACE.

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

#### 6-DATE OF BIRTH.

Feb. 17, 1882

#### 7-AGE.

32 yrs. 10 mos. 13 da.

IF LESS than 1 day.

hrs. or min.

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

None

#### 9-BIRTHPLACE, (State or Country).

Baltimore

#### 10-NAME OF FATHER.

Henry Schrader

#### 11-BIRTHPLACE OF FATHER (State or Country).

Germany

#### 12-MAIDEN NAME OF MOTHER

Elizabeth Heig

#### 13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles F. Roseway

(Address) 1232 S. Carey St.

### 16-DATE OF DEATH.

Dec 1, 30, 1914

17-I HEREBY CERTIFY, That I attended deceased from

Aug. 15, 1911, to Dec 30, 1914

that I saw him alive on Dec. 29, 1914

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis.

### CONTRIBUTORY

(Secondary)

(Duration) 3 yrs. mos. da.

(Signed) M. G. Schneider M. D.

101 (Address) 101 S. Carey St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

### 19-PLACE OF BURIAL OR REMOVAL.

### DATE OF BURIAL.

London Park Bur. Jan. 2, 1915

### 20-UNDERTAKER

### ADDRESS

for friends on 217 S. Pine

DEC 31 1914

HARRY O. ANDREWS,

Filed....., 191.. Burial Permit Clerk

Registrar.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81507

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81507

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *18* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *546 W. Fayette St.* St. yrs. mos. da.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*male*

## 4-COLOR OR RACE,

*white*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*single*

## 6-DATE OF BIRTH,

*Sept 21, 1864*  
(Month) (Day) (Year)

## 7-AGE,

*50 yrs. 3 mos. 8 da.*

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*none*

## 9-BIRTHPLACE,

(State or Country),

*Maryland*

## 10-NAME OF FATHER,

*unknown*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*unknown*

## 12-MAIDEN NAME OF MOTHER

*unknown*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

*A. B. Curry*

(Address),

*18. Hotel*

DEC 31 1914

HARRY P. ANDREWS,

Marial Permit Clerk.

Filed..... 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Dec 29, 1914*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 24* 1914, to *Dec 29* 1914, that I saw him alive on *Dec 29* 1914, and that death occurred, on the date stated above, at *459 m.* The CAUSE OF DEATH\* was as follows:*Acute myocardial infarction*(Duration) yrs. mos. da. *9*

## CONTRIBUTORY (Secondary)

*Acute Calculus, right*(Duration) yrs. mos. da. *9*(Signed) *William Mont* M. D.*Dec 29, 1914* (Address) *18. Hotel*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da. *unknown*Where was disease contracted, if not at place of death? *unknown*Former or usual residence *546 W. Fayette St.*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Eastern Trust Co. Dec 31, 1914*

## 20-UNDERTAKER

## ADDRESS

*For Foundation Inc 217 S. Penn*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C81508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 C81508  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *415 N. Patterson Park Ave* ST. *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *415 N. Patterson Park Ave* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *April 4th*, 18*35*  
(Month) (Day) (Year)

7-AGE, *79* yrs. *8* mos. *27* ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *at Home*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *William S. West*

11-BIRTHPLACE OF FATHER (State or Country), *Eng.*

12-MAIDEN NAME OF MOTHER *Wideman*

13-BIRTHPLACE OF MOTHER (State or Country), *Denmark*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward S. Vade*

(Address) *415 N. Patterson Park Ave.*

15-DEC 31 1914 HARRY O. ANDREWS  
Filed. 191. Burial Permit 018

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec 30*, 191*4*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct. 3*, 191*3*, to *Dec. 30*, 191*4*, that I saw her alive on *Dec. 30*, 191*4*, and that death occurred, on the date stated above, at *5:30* m. The CAUSE OF DEATH\* was as follows:

*Valvular heart disease*  
(Duration) *3* yrs. *3* mos. *—* ds.

18-CONTRIBUTORY (Secondary) *Old age*  
(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *William H. Johnson* M. D.  
*Dec 31*, 191*4* (Address) *2017 E. Pratt St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cambridge Md* DATE OF BURIAL, *Dec 31*, 191*4*

20-UNDERTAKER *H. Hughes 17 S. Broadway* ADDRESS

WHITE PLAINLY, WITH UNFADING INK. THIS IS TO BE WRITTEN IN PLAIN, WITHOUT ORNAMENT. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81509

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81509

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

2. FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 63 yrs. 3 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

7. AGE

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed), M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR CREMATION

DATE OF BURIAL

DEC 31 1914

Filed

Serial Permit Office

REGISTRAR

Loudon Park Cem. Jan. 1st, 1915

Philip Seewald & Son 1192 E. Cutaw St.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081510

HEALTH DEPARTMENT—CITY OF BALTIMORE

167 081510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

HARRY O. ANDERSON

1914

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Burns & Clothing ignited from stove while playing. Accident.

CONTRIBUTORY (Secondary)

(Signed) ... (Coroner) ...

1914 (Address) ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the 8 yrs... mos... ds. State 8 yrs... mos... ds.

Where was disease contracted, if not at place of death?...

1842 Eagle St. Former or usual residence 1842 Eagle St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

C81511

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1428 Fairmount Ave ST. 5 WARD)

## FULL NAME

Sarah Durn

Residence in Baltimore: No.

1428 Fairmount Ave

St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX.

Female

## 4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Infant

## 6-DATE OF BIRTH,

Dec 14<sup>th</sup>, 1914

## 7-AGE,

yrs. 13 mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

## 9-BIRTHPLACE, (State or Country),

Md

## 10-NAME OF FATHER,

Unknown

## 11-BIRTHPLACE OF FATHER (State or Country),

Unknown

## 12-MAIDEN NAME OF MOTHER,

Mandy Durn

## 13-BIRTHPLACE OF MOTHER (State or Country),

Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 DEC 31 1914.

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 26<sup>th</sup>, 1914

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

I find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia

## CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) Elijah Russell M. D.

Dec 27, 1914 (Address) 423 N Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

CITY OF MARYLAND

DEC 31 1914

## 20-UNDERTAKER

## ADDRESS

Commissioner Health

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Heart disease

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Coroner.)

Dec 7-1-1914 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

CITY OF MARYLAND

DEC 31 1914

20-UNDERTAKER

ADDRESS

Comptroller Health.

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH EMPLOYING INSTITUTION



C81513

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81513

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 Wilkens ave ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2424 Wilkens ave St.;

yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

## 6-DATE OF BIRTH

May 2

1893

## 7-AGE,

79 yrs., 7 mos., 27 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9-BIRTHPLACE,  
(State or Country),

Germany

## 10-NAME OF FATHER,

John Koppel

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

H. Kattenfelder

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Bienenstein

(Address) 2424 Wilkens ave

## 15-

Filed

12/31/14 1914

Serial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 29, 1914

(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Oct 18, 1914, to Dec 29, 1914,

that I saw him alive on Dec 29, 1914,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH\* was as follows:

Bright's Disease  
Secondary of Heart  
(Duration) yrs. 2, mos. 11, ds.CONTRIBUTORY  
(Secondary)Bright's Disease  
(Duration) yrs. 2, mos. 11, ds.

(Signed) Dr. G. W. Kermack M. D.

Dec 30, 1914 (Address) 708 E. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Truman's Cemetery Jun. 1, 1914

## 20-UNDERTAKER

## ADDRESS

Louis Hermann 22 S. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81514

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 C81514

CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. 1713 Druidhill ave.  
FULL NAME William H. Goodwen,  
(Residence in Baltimore: No. 216 W. Biddle st.

ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, Colored, 5-SINGLE, Married, MAILED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Could not ascertain, /  
(Month) (Day) (Year)

7-AGE, 31 yrs., ? mos., ? ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Stevedore,  
(b) General nature of industry, business, or establishment in which employed (or employer), Water-front.

9-BIRTHPLACE, (State or Country), Virginia,

10-NAME OF FATHER, ? ? Goodwen,

11-BIRTHPLACE OF FATHER (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Lucy Ann ? ?

13-BIRTHPLACE OF MOTHER (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Goodwen,

(Address) 216 W. Biddle st.

15-ROBERT KRAUTER,  
Filed 12/31/14 1914 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1914.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accidentally asphyxiated by illuminating gas.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. Francis Hempel M. D.  
(Coroner.)

Dec. 28, 1914 (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, .....

20-UNDERTAKER ADDRESS

FOR ANATOMICAL PURPOSES

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81515

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81515

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH (Month) (Day) (Year)

7-AGE 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

ROBERT KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 1914, to Dec 30, 1914.

that I saw her alive on Dec 30, 1914.

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic Interst Nephritis

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

Jan 3, 1915

20-UNDERTAKER

ADDRESS

Geo W Little

531 Monmouth Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81516

C81516

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Fairmount Ave 6

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. 1506 Fairmount Ave

St. yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Black 5-SINGLE, ~~WIDOWED~~ OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH Apr. 11<sup>th</sup>, 1841 (Month) (Day) (Year)

7-AGE 73 yrs. 8 mos. 17 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Labour (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Calvert Co. Md.

10-NAME OF FATHER unknown 11-BIRTHPLACE OF FATHER (State or Country) Calvert Co Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Priscilla Brown

(Address) 1506 Fairmount Ave

15-DEC 31 1914

Filed 191

ROBERT KRAUTER

Bureau Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec. 28<sup>th</sup>, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24 1914, to Dec 27 1914, that I saw him alive on Dec. 27 1914, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH\* was as follows:

Paralysis 2 (Duration) 3 days (Right side) General Debility (Signed) H. W. Slater M.D. Dec. 28 1914, (Address) 1703 W. Day St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery

Jan. 1, 1915

UNDERTAKER

ADDRESS

Alfred J. Freedland Schaefer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81517

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 S. Charles

ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Elizabeth Wagner

(Residence in Baltimore: No. 1904 S. Charles

St.; 54 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

7-AGE,

54 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housework  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Balto., Md.

10-NAME OF FATHER,

Henry Michaels

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Johanna Herring

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jacob Wagner

(Address)

1904 S. Charles

15

DEC 31 1914

ROBERT S. BRADLEY,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 30 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY that I attended deceased from Dec 8 1914, to Dec 30 1914, that I saw her alive on Dec 29 1914, and that death occurred, on the date stated above, at 12:30 a.m. The CAUSE OF DEATH\* was as follows:

The CAUSE OF DEATH\* was as follows:

Meningitis (Duration) 36 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D. Dec 31 1914 (Address) 1279 William St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cemetery

Jan 1, 1915

20-UNDERTAKER

ADDRESS

J. M. E. Egan

422 Light St.

WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 C81518

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1818 E. Madison* St.:

2-FULL NAME

*John P. Graff*

(Residence in Baltimore: No. *1818 E. Madison*

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*Sept 22nd*

*1875*

7-AGE,

*39* yrs. *3* mos. *9* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

*Balto. Md.*

10-NAME OF FATHER,

*Raymond Graff*

11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Mary E. Kemper*

13-BIRTHPLACE OF MOTHER (State or Country),

*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Graff*

(Address) *414 S. Wallace St.*

15-

Filed

*DEC 31 1914*

*ROBERT KRAUTER,*  
*Morial Permit Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Dec*

*31*

*1914*

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* and that said deceased came to *his* death (Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of the lungs*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*1st anemia*

(Duration) yrs. mos. ds.

(Signed) *Joseph J. Schmitt* M. D.

(Coroner)

*Dec 31 1914* (Address) *423 N. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Schwartz Cemetery*

*Jan 2nd 1915*

20-UNDERTAKER

*Lilly Zuler*

ADDRESS

*400 S. Wolfe St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81519

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and omit No. 18.)

2-FULL NAME

Residence in Baltimore: No.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JAN 1 - 1915

HARRY O. ANDREWS,

191... Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81520

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81520

## PLACE OF DEATH

CITY OF BALTIMORE (No. *411 N. Gilmore*

## FULL NAME

*Ella Holland*St. *19*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *Rine & Dawson Alley*

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*Colored*

## 5-SINGLE,

*Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Unknown*, 1890  
(Month) (Day) (Year)

## 7-AGE,

*24*

yrs. mos. ds.

If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*9-BIRTHPLACE,  
(State or Country),*Md*

## 10-NAME OF FATHER,

*Isaac Benson*11-BIRTHPLACE OF FATHER  
(State or Country),*Md*

## 12-MAIDEN NAME OF MOTHER

*Eliza Norris*13-BIRTHPLACE OF MOTHER  
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carlisle Norris*(Address) *411 N. Gilmore St*

## 15-

JAN 1 - 1915

Filed

191

HARRY O. ANDREWS,  
Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 10-DATE OF DEATH,

*Dec. 29<sup>th</sup>*, 1914  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *Autopsy*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Autopsy*  
(Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH was as follows:

*Pulmonary Tuberculosis*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Samuel Kimbrey* M. D.  
(Coroner)*Dec 31*, 1914 (Address) *2302 Madison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Old Auburn Cemetery*

## 20-UNDERTAKER

*John H. Goodwin*

## DATE OF BURIAL,

*Jan. 9*, 1915

## ADDRESS

*142 Union*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81521

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81521

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Little Harsh ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1809 Little Harsh

St.; 25 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

Unknown, 1889  
(Month) (Day) (Year)

## 7-AGE

25

If LESS than 1 day.

yrs. mos. ds.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

Maryland.

## 10-NAME OF FATHER,

Conrad Domes

## 11-BIRTHPLACE OF FATHER

(State or Country), Germany

## 12-MAIDEN NAME OF MOTHER

Sophia Burger

## 13-BIRTHPLACE OF MOTHER

(State or Country), Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Arthur Domes

(Address)

1809 Little Harsh St.

## 15-

JAN 1 - 1915

HARRY O. ANDREWS,

Filed

1915 Serial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

December 31, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 29 1914, to Dec. 31 1914, that I saw her alive on Dec. 30 1914, and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH\* was as follows:

Communications

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Epilepsy

(Signed) Paul Bagwell M. D.  
Dec. 31, 1914 (Address) 1837 Penna. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Jordan Park

## DATE OF BURIAL

Jan 1, 1915

## 20-UNDERTAKER

Paul Cook

## ADDRESS

507 E. N. Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81522

## CERTIFICATE OF DEATH

154  
REGISTERED NO. C

C81522

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1234 Carroll St.)

2 FULL NAME

(Residence in Baltimore: No. 1234 Carroll St.)

WARD 21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 45 yrs. — mos. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (In the life word) *Widow*

6 DATE OF BIRTH *Sept. 21, 1828*  
(Month) (Day) (Year)

7 AGE *78* yrs. *3* mos. *10* ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Germany*

10 NAME OF FATHER *Germany Lenz*

11 BIRTHPLACE OF FATHER (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *not know*

13 BIRTHPLACE OF MOTHER (State or country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry Simon*

(Address) *1234 Carroll St.*

15 JAN 1 - 1915. HARRY O. ANDREWS, REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *December 20, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from *Aug 12*, 1914, to *Dec 20*, 1914, that I saw him alive on *Dec 26*, 1914, and that death occurred, on the date stated above, at *10:45 a.m.* The CAUSE OF DEATH\* was as follows:

*Infirmities of old age*  
(Duration) *Yrs. 45*

Contributory (SECONDARY) (Duration) *Yrs. 45*

(Signed) *Augustus D. Lee* M. D. *Dec 20, 1914* (Address) *1433 W. Lombard St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *Yrs. — mos. — ds.* In the State *Yrs. — mos. — ds.* Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Cath. St. Paul Cem.* DATE OF BURIAL *Jan 1, 1915*

20 UNDERTAKER *Thos. J. Dilligan* ADDRESS *246 Columbia*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81523

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81523

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST.: WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>married</i> (Write the word.)
6-DATE OF BIRTH, <i>May 10</i> , <i>1841</i> (Month) (Day) (Year)		
7-AGE, <i>72</i> yrs. <i>7</i> mos. <i>21</i> ds.		If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, establishment in which employed (or employer)...		

9-BIRTHPLACE, (State or Country), <i>Med.</i>	10-NAME OF FATHER, <i>Thomas Hood</i>
11-BIRTHPLACE OF FATHER (State or Country), <i>Med.</i>	12-MAIDEN NAME OF MOTHER, <i>Sant known</i>
13-BIRTHPLACE OF MOTHER (State or Country), <i>Sant known</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Miss William Hood*  
(Address) *31 E. North av*

15-  
JAN 1 - 1915  
Filed... 191...  
HARRY O. ANDREWS,  
Bureau Permit Clerk  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
*Dec 31*, *1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remaining described above, held an...  
(Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said...  
and that said deceased came to... death  
topsy or inquiry.)  
on the day stated above.

THE CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) *Harry O. Andrews* M. D.  
(Coron.)  
Jan 1, 1915 (Address) *31 E. North av*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, *Woodbine Med.* DATE OF BURIAL, *Dec 1, 1915*

20-UNDERTAKER, *Wm Cook* ADDRESS, *30 E. North*

C81524

## HEALTH DEPARTMENT—CITY OF BALTIMORE

170 C81524

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *138 Old York Road*;WARD) *9*

## REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. *138 Old York Road*

St.; yrs.; mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*Colored*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Married*

## 6-DATE OF BIRTH,

*June 22nd 1876*  
(Month) (Day) (Year)

## 7-AGE,

*38 yrs. 6 mos. 8 ds.*

## IF LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*9-BIRTHPLACE,  
(State or Country),*MD*

## 10-NAME OF FATHER,

*Jamer Cunnis*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*MD*

## 12-MAIDEN NAME OF MOTHER

*Lizzie Boose*13-BIRTHPLACE OF MOTHER  
(State or Country),*Anne Amundelch*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lewis Smith*(Address) *138 Old York Road*

## 15-

Filed

JAN 1 - 1915

HARRY O. ANDREWS

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*December 30th 1914*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 23rd 1914*, to *Dec 30th 1914*,that I saw her alive on *Dec 30th 1914*, and that death occurred, on the date stated above, at *1.30 AM*

The CAUSE OF DEATH\* was as follows:

*C. Brown Coreuchynator*  
*Myeloid*  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Signed) *Geo. H. Murray M.D.*  
*Dec 30th 1914* (Address) *2537 Greenmount Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

*Mt. Auburn Cem.**Jan 2nd 1915*

## 20-UNDERTAKER

## ADDRESS

*Theodore White**1702 Long St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1037 N. Central av.* *10th* WARD)2-FULL NAME *Frederick R. Bruns*Residence in Baltimore: No. *1037 N. Central av.*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *60* yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the Word.) *Widowed*DATE OF BIRTH, *February 6, 1829*  
(Month) (Day) (Year)7-AGE, *85* yrs., *10* mos., *24* ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Shoemaker*  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *John Bruns*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Philip F. Sigel*(Address) *1037 N. Central av.*15-*JAN 1 - 1915* HARRY O. ANDREWS,  
Filed..... 191..... Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *December 30, 1914*  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Sept. 24, 1914*, to *Dec. 30, 1914*, that I saw him alive on *Dec. 28, 1914*, and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cancer of Liver*  
*Diagnosis*  
(Duration) *1* yrs. *6* mos. *6* ds.CONTRIBUTORY (Secondary).....  
(Duration)..... yrs. mos. ds.(Signed) *Edwin B. Fenby, M. D.*  
*Dec. 31, 1914* (Address) *1223 N. Caroline St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cem.* DATE OF BURIAL, *Jan. 2, 1915*20-UNDERTAKER *A. Pink & Son* ADDRESS *9154 Gay St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Community Hospital* ST.; *4* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Laurel, Md.* St.; *—* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word.) *Widow*

## 6-DATE OF BIRTH,

*Nov 10, 1832*  
(Month) (Day) (Year)

## 7-AGE,

*82* yrs., *30* mos., *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Physician*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),*Maryland*

## 10-NAME OF FATHER,

*John Cronin*11-BIRTHPLACE OF FATHER  
(State or Country),*Id*

## 12-MAIDEN NAME OF MOTHER

*Mary Mallory*13-BIRTHPLACE OF MOTHER  
(State or Country),*Id N.Y.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Cronin*(Address) *Laurel, Md.*

## 15-

JAN 1 - 1915

Filed *191* Burial Permit *010*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Dec 29, 1914*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Nov 18, 1914, to Dec 29, 1914,*that I saw him alive on *Dec 29, 1914,*and that death occurred, on the date stated above, at *7:15* p. m.

The CAUSE OF DEATH\* was as follows:

*Cholelithiasis with Ruptured gall bladder*  
(Duration) *1* yrs., *1* mos., *14* ds.CONTRIBUTORY  
(Secondary)*Infarction of heart*  
(Duration) *1* yrs., *1* mos., *14* ds.(Signed) *John Cronin* M. D.*Dec 30, 1914* (Address) *Community Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *1* mos., *14* ds. In the *82* yrs., *1* mos., *20* ds.Where was disease contracted, if not at place of death? *Usual Residence*Former or usual residence *Laurel, Md.*

## 19-PLACE OF BURIAL OR REMOVAL.

*Laurel Md*

## DATE OF BURIAL,

*Jan 1, 1915*

## 20-UNDERTAKER

*Wm J. Tidner & Son* ADDRESS *425 W Camden*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81527

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

042 C81527

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *14*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. *1326 Division*

St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

## 6-DATE OF BIRTH

*Not known*

(Month)

(Day)

(Year)

## 7-AGE

*54*

yrs. mos. da.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*House work*

## 9-BIRTHPLACE, (State or Country),

*Balt Md*

## 10-NAME OF FATHER,

*John Haden*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Balt Md*

## 12-MAIDEN NAME OF MOTHER

*Rochael Haden*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Balt Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Jelly Jones*

(Address)

*5-43-W. Lafayette St*

## 15-

JAN 1 - 1915

HARRY O. ANDREWS,

Filed... 191... Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*December**30**1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 24* 1914 to *Dec 30* 1914that I saw him alive on *Dec 30* 1914and that death occurred, on the date stated above, at *9 1/2* m.

The CAUSE OF DEATH\* was as follows:

*Epithelioma of Vulva**Stage 4*

(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

*Cardiac asthma*

(Duration) yrs. mos. da.

(Signed) *W. B. Tracy* M. D.*Dec 30*, 1914. (Address) *113 W. Division St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *1326 Division St.*

## 19-PLACE OF BURIAL OR REMOVAL.

*Mount Zion Cem.*

## DATE OF BURIAL

*Jan 1*, 1915.

## 20-UNDERTAKER

*John H. Owens*

## ADDRESS

*1122 Division St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81528

## HEALTH DEPARTMENT—CITY OF BALTIMORE

105 C81528

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *916 Harlem* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *916 Harlem* St.; *55* yrs., *2* mos. *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Female*

4-COLOR OR RACE,

*White*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*June 14*, 18*49*  
(Month) (Day) (Year)

7-AGE,

*65* yrs., *6* mos., *16* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*House duties*

9-BIRTHPLACE,

(State or Country),

*Germany*

10-NAME OF FATHER,

*John R. Riemer*

11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Mary Mandryler*

13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martin C. Riemer*(Address) *916 Harlem Av*

15-

JAN 1 - 1915

HARRY O. ANDREWS

Filed..... 191..... Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*one 21*, 191*4*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *one 1* 191*4*, to *one 21* 191*4*, that I saw h*er* alive on *one 21* 191*4*, and that death occurred, on the date stated above, at *58* m.

The CAUSE OF DEATH\* was as follows:

*Emphysema*(Duration).....yrs. *1* mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs. *1* mos. ....ds.

(Signed)..... M. D.

*one 1* 191*4* (Address) *92 & 4 Cornell*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western**Jan 2, 1915*

20-UNDERTAKER

ADDRESS

*Geo W Little**531 Fremont*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81529

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH **Maryland General Hospital,**  
CITY OF BALTIMORE (NO. **Linden ave. & Madison st.** ST. **15** WARD)  
2-FULL NAME **Grace I. Smith,**  
(Residence in Baltimore: No. **632 Baker street,** St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, **Female,** 4-COLOR OR RACE, **Colored,** 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, **Single,** (Write the word.)  
6-DATE OF BIRTH, **August 20th, 1913.** (Month) (Day) (Year)  
7-AGE, **1 yrs. 4 mos. 9 ds.** If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, **None.**  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), **Baltimore, Md.**

PARENTS.  
10-NAME OF FATHER, **Noah Smith,**  
11-BIRTHPLACE OF FATHER (State or Country), **Maryland,**  
12-MAIDEN NAME OF MOTHER, **Mattie Carrington,**  
13-BIRTHPLACE OF MOTHER (State or Country), **Virginia.**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) **Mattie Smith,**  
(Address) **632 Baker street.**

15- **JAN 1 - 1915** HARRY O. ANDREWS,  
Filed **191** **Marital Permit Clerk**  
Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **December 29th 1914.** (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **autopsy** (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) **autopsy** and that said deceased came to **her** death on the day stated above.

The CAUSE OF DEATH\* was as follows:

**Hydropericarditis.**

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) **Frederick R. Rimpel** M. D.

(Coroner)

**Dec. 30, 1914.** (Address) **1103 Valley st.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death **one hour** ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? **632 Baker street.**

Former or usual residence **632 Baker street.**

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

**St. Auburn**

**Jan 1, 1915**

20-UNDERTAKER

ADDRESS

**James H. Dennis** **1303 Reisterstown**



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1114 Little Wilson st. St.

WARD)

### 2-FULL NAME

Agnes Taylor,

(Residence in Baltimore: No.

1114 Little Wilson st.

St. yrs. — mos. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX,

Female,

#### 4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,

#### 6-DATE OF BIRTH,

August 17th, 1866.  
(Month) (Day) (Year)

#### 7-AGE,

48 yrs. 4 mos. 13 ds.

If LESS than 1 day,  
...hrs. or ...min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laundress,

(b) General nature of industry, business, or establishment in which employed (or employer).

#### 9-BIRTHPLACE, (State or Country),

Virginia,

#### 10-NAME OF FATHER,

Unknown,

#### 11-BIRTHPLACE OF FATHER (State or Country),

Unknown,

#### 12-MAIDEN NAME OF MOTHER

Mary Tyler,

#### 13-BIRTHPLACE OF MOTHER (State or Country),

Virginia.

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Lillian Ayers,  
(Informant)

1114 Little Wilson st.  
(Address)

#### 15-

JAN 1 - 1915

HARRY O. ANDREWS

Filed 191... Serial. Peralt. Cle.

Registrar.

### REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

December 30th, 1914.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Myocarditis,

(Duration) yrs. mos. ds.

#### CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick Hempel, M. D.  
(Coroner.)

Dec. 30, 1914 (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

1914

#### 20-UNDERTAKER

#### ADDRESS

James H. Davis

C81531

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

113  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1869 1/2 Gay

ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

## 2-FULL NAME

(Residence in Baltimore: No. 1869 1/2 Gay

St.: — yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

June 27

(Month)

1890

(Day)

(Year)

7-AGE,

24

yrs.

6

mos.

3

ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Pa

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Louis Koch

(Address), 1869 1/2 Gay St

15-

Filed

JAN 1 - 1915

191

HARRY O. ANDREWS,

Morial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 30

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 27 1914

to Dec 30 1914

(Year)

that I saw him alive on Dec 30 1914

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

Echinococcus of Liver

(Duration)

1

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

Heart Failure

yrs.

mos.

ds.

(Signed)

J. E. Thanner

M. D.

Dec 30 1914 (Address) 1301 N. Pot Park

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Balls Blowing

Jan 1, 1915

20-UNDERTAKER

ADDRESS

Rott &amp; Turner

144 1/2 Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.





N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

C81533

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81533

PLACE OF DEATH

CERTIFICATE OF DEATH

CITY OF BALTIMORE (No. *204 E. Read*)  
FULL NAME *Hiraitta Albers*  
(Residence in Baltimore: No. *204 E. Read St*)

REGISTERED NO. C

ST. *11* WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

1. SEX *Female*  
2. COLOR OR RACE *White*  
3. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*  
4. DATE OF BIRTH *September 13, 1844*  
(Month) (Day) (Year)  
5. AGE *70* yrs. *3* mos. *18* ds. or min.?  
6. OCCUPATION (a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
7. BIRTHPLACE (State or country) *Maryland*

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 31st*, 1914  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 1*, 1914, to *Dec. 30*, 1914, that I saw her alive on *Dec. 30*, 1914, and that death occurred, on the date stated above, at *11 A.M.*

The CAUSE OF DEATH\* was as follows:  
*chronic interstitial nephritis*

Contributory (SECONDARY) (Duration) *2* mos. *0* ds. *arthritic deformity*

(Signed) *John S. Fisher* M. D.  
*Dec. 31, 1914* (Address) *110 Belvidere Ave. Baltimore*

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. In the ds. State yrs. mos. ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Greenmount Cemetery* DATE OF BURIAL *1-2*, 1914

20. UNDERTAKER *Henry W. Fisher Sons Co. McNeill & Orchard*

15. JAN 1 - 1915 HARRY O. ANDREWS,  
Serial Permit Clerk  
REGISTRAR

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *John S. Fisher*  
(Address) *110 Belvidere Ave*

PARENTS  
10. NAME OF FATHER *Dr. Henry Albers*  
11. BIRTHPLACE OF FATHER (State or country) *Germany*  
12. MAIDEN NAME OF MOTHER *Ann Eliza Fisher*  
13. BIRTHPLACE OF MOTHER (State or country) *Maryland*



C81534

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81534

## PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

Nov 30, 1886  
(Month) (Day) (Year)

## 7-AGE,

78 yrs. 1 mos. 1 da.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9-BIRTHPLACE, (State or Country),

Maryland

## 10-NAME OF FATHER,

Allen Reynolds

## 11-BIRTHPLACE OF FATHER (State or Country),

Maryland

## 12-MAIDEN NAME OF MOTHER

E. Weaver

## 13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Shipley (Daughter)

(Address) 607 E Biddle St

## 15-

Filed

JAN 1 - 1915

191

HARRY O. ANDREWS

Serial Permit Order

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec 31, 1914  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 26, 1914, to Dec 31, 1914,

that I saw her alive on Dec 31, 1914,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) W. W. Pearce M. D.

Jan 1, 1915 (Address) 5 E Preston

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Cedar Hill

Jan 2, 1915

## 20-UNDERTAKER

## ADDRESS

Armstrong &amp; Denny Co

715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81535

1-PLACE OF

CITY OF BALTIMORE: (No. 1714 S. Charles St.)

FULL NAME

(Residence in Baltimore: No. 1714 S. Charles St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 4 mos. 27 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.) Single

6-DATE OF BIRTH,

Aug 4, 1914  
(Month) (Day) (Year)

7-AGE,

yrs. 4 mos. 27 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country),

Md. (City)

10-NAME OF FATHER,

Harry W. Callender

11-BIRTHPLACE OF FATHER  
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Margaret Thomas

13-BIRTHPLACE OF MOTHER  
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Callender  
1714 S. Charles St.

15-

JAN 1 - 1915

HARRY O. ANDERSON,

Baptist. Permit. Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 31, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1914, to Dec 31 1914, that I saw him alive on Dec 31 1914, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchopneumonia

(Duration) yrs. 4 mos. 4 ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. 1 mos. 1 ds.

(Signed) R. O. Anderson, M. D.

Dec 31, 1914 (Address) 1644 Hancock St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem.

DATE OF BURIAL,

Jan. 2, 1915

20-UNDERTAKER

J. F. M. Conley

ADDRESS

39 E. Towson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81536

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

64  
REGISTERED NO. C

C81536

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *1936 E. Fayette* ST.: *6* WARD)FULL NAME *John A. Batzer*(Residence in Baltimore: No. *1936 E. Fayette St.*St.: *64* yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *Male*2-COLOR OR RACE, *White*3-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*4-DATE OF BIRTH, *June*, *1850*

(Month)

(Day)

(Year)

7-AGE, *64* yrs., *6* mos., ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *John Batzer*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *not known*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mary Batzer*(Address) *1936 E. Fayette*

15-

JAN 2 - 1915

HARRY O. ANDREWS,  
Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec 30*, *1914*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *Dec 30*, *1914*, to *Dec 30*, *1914*that I saw him alive on *Dec 30*, *1914*and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) *Heart failure*Signed, *E. C. Leitch*

Dec 31, 1914

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Peter's*DATE OF BURIAL, *Jan 3*, *1915*20-UNDERTAKER, *J. J. Kerr*ADDRESS, *1914 E. Fayette*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81537

28

C81537

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Thomas ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mary G. Merriam(Residence in Baltimore: No. 43 Columbia St.; 1 yrs., 6 mos., 6 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH

June 7th, 1884  
(Month) (Day) (Year)

## 7-AGE

30 yrs., 6 mos., 24 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

DomesticHousewife

## 9-BIRTHPLACE,

(State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE

(State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE

(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JAN 2 - 1915

HARRY O. ANDERSON,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

12/31, 1914  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June, 1913, to 12/31, 1914,that I saw her alive on 12/20, 1914,and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Phth. Tuberculosis(Duration) 1 yrs., 6 mos., 6 ds.

## CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 6 mos., 6 ds.(Signed) A. Lee Elless, M. D.12/31, 1914. (Address) 924 Wood, W.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Lorraine CourtJan. 2, 1915

## 20-UNDERTAKER

## ADDRESS

W. J. DickinsonNorth

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.





N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81539

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *502 Pearl* ST. *17* WARD)

2-FULL NAME *Veronica Smith*

(Residence in Baltimore: No. *502 Pearl* St. *17* yrs. *0* mon. *0* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *Colored*

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word) *Widow*

6-DATE OF BIRTH *Unknown* 1891

7-AGE *23* yrs. *0* mos. *0* ds. or *0* min.?

If LESS than  
1 day, *0* hrs.  
*0* min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Housewife*

9-BIRTHPLACE  
(State or country)

*Ratio*

10-NAME OF FATHER *Mr. J. H. Smith*

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER *Mary Collins*

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Mary Smith*

(Address) *502 Pearl St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec 29, 1914*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 25*, 191*4*, to *Dec 29*, 191*4*, that I saw h*er* alive on *Dec 28*, 191*4*, and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH\* was as follows:

*Typhoid Fever*

(Duration) *0* yrs. *0* mos. *0* ds.

Contributory  
(SECONDARY)

(Signed) *J. H. Smith*

*12/30*, 191*4* [Address] *2005 S. Hill Av*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Laurel Cem.*

DATE OF BURIAL *1/1*, 191*5*

20-UNDERTAKER *Sam M. Sturley*

ADDRESS *578 7th Biddle*

JAN 2 - 1915

HARRY O. ANDREWS,

Filed....., 191

Burial Permit Officer  
REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

81540

C81540

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2-CITY OF BALTIMORE: (No.

ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3-FULL NAME

(Residence in Baltimore: No.

St.; — yrs. — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

4-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 2 - 1915

HARRY O. ANDREWS,

191. Burial Permit. Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 1, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31, 1914, to Jan 1, 1915, that I saw him alive on Jan 1, 1915, and that death occurred, on the date stated above, at 2:56 p.m.

The CAUSE OF DEATH\* was as follows:

General Arterio Sclerosis

CONTRIBUTORY (Secondary)

(Signed) H. S. Kuhlman M. D.

Jan 1, 1915. (Address) Mercy Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81541

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

170 C81541

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mercy Hospital 4

St.;

WARD)

## 2-FULL NAME

Ellen Wilson

(Residence in Baltimore: No.

414 Courtland St.

St.;

yrs.,

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, or BOTH

Female

Black

Married

6-DATE OF BIRTH,

May

(Month)

16

(Day)

1891

(Year)

7-AGE,

44

yrs.,

mos.,

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,  
(State or Country),

Va

10-NAME OF FATHER,

Winston Coleman

11-BIRTHPLACE OF FATHER  
(State or Country),

Caroline Co Va

12-MAIDEN NAME OF MOTHER

Ellen Banks

13-BIRTHPLACE OF MOTHER  
(State or Country),

West Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Burton

(Address)

418 Courtland

15-

JAN 2 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 1, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Dec 30, 1914

to

Jan 1, 1915

1915

that I saw her alive on

Jan 1, 1915

1915

and that death occurred, on the date stated above, at

5:50 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Paraneurmatous  
Nephritis

(Duration)

2 years

CONTRIBUTORY  
(Secondary)

Trauma

(Duration)

about 5 mos.

(Signed)

Edward P. Smith

M. D.

Jan 1, 1915

(Address) Mercy Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

25

yrs.

State

mos.

ds.

Where was disease contracted, if not at place of death?

Don't know

Former or usual residence

414 Courtland St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wilford Station, Caroline County Va

Jan 3rd, 1915

20-UNDERTAKER

County Va

ADDRESS

Gelijah P. Rife

102 E Mulberry

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C81542

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 Columbia Ave

ST. 21

WARD

REGISTERED No. C

2-FULL NAME

Ida May Dickerson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 803 Columbia Ave

30 yrs., 7 mos., 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

May 5<sup>th</sup>, 1884  
(Month) (Day) (Year)

7-AGE,

30 yrs., 7 mos., 25 ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Balt. Md.

10-NAME OF FATHER,

George E. Schofield

11-BIRTHPLACE OF FATHER  
(State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Ida E. Sanner

13-BIRTHPLACE OF MOTHER  
(State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George E. Schofield

(Address)

Immetsburg Md.

15. JAN 2 - 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec. 30<sup>th</sup>, 1914  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Hemorrhage

(Duration) yrs. mos. ds.

(Signed) Samuel Weinberg, M. D.

Dec. 31<sup>st</sup>, 1914 (Address) 2302 Madison Ave

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cem

DATE OF BURIAL,

Jan 2, 1915

20-UNDERTAKER,

John B. Cook

ADDRESS

11002 W. Pratt

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81543

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

81543

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *1093 N Fayette St* ST. *18* WARD)  
2-FULL NAME *John P. Hodges*  
(Residence in Baltimore: No. *1093 N Fayette St* St.; *74* yrs. *7* mos. *1* ds.)

REGISTERED NO. C.....  
(If death occurred in a hospital or institution, give its NAME instead of street and number and RN Out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *W* 5-SINGLE *Wid*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)  
6-DATE OF BIRTH *Unknown* (Month) (Day) (Year)  
7-AGE *74* yrs. *7* mos. *1* ds. or min.?  
8-OCCUPATION (a) Trade, profession or particular kind of work *Ship Carpenter*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

*93 Me*

### PARENTS

10-NAME OF FATHER *James Hodges*  
11-BIRTHPLACE OF FATHER (State or country) *Balto*  
12-MAIDEN NAME OF MOTHER *Unknown*  
13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Harry O. Andrews*

(Address)

*1093 N Fayette St*

15-

JAN 2 - 1915

HARRY O. ANDREWS,

Registrar

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Dec 3, 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 10, 1914*, to *Dec 3, 1914*, that I saw him alive on *Dec 30, 1914*, and that death occurred, on the date stated above, at *3:00 p.m.*  
The CAUSE OF DEATH\* was as follows:

*Organic Disease of Heart*

Contributory (SECONDARY)

*Duration* yrs. *6* mos. *1* ds.

(Signed)

*V. L. Norwood* M. D.  
*Jan 1, 1915* [Address] *939 N Fayette St*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mount Olivet*

*Jan 2, 1915*

20-UNDERTAKER

ADDRESS

*Amstrong & Sons 715 Light*

C81544

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

151  
REGISTERED NO. C

C81544

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hwy* ST. *6* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

8 *Baby Gregg*  
Residence in Baltimore: No. *427 N Broadway* St.; yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *single*, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Dec 31, 1914*  
(Month) (Day) (Year)7-AGE, *16 hrs* IF LESS than 1 day, yrs., mos., ds. .... hrs. or .... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *ms City*10-NAME OF FATHER, *Harman Gregg*11-BIRTHPLACE OF FATHER (State or Country), *W Va*12-MAIDEN NAME OF MOTHER, *Bertie Sheets*13-BIRTHPLACE OF MOTHER (State or Country), *W Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. M. Ficke*(Address) *Johns Hopkins Hospital*

15- JAN 2 - 1915

HARRY O. ANDERSON

Filed..... 191... *Burial Permit Clerk* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 1, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 31, 1914*, to *Jan 1, 1915*, that I saw her alive on *Dec 31, 1914*, and that death occurred, on the date stated above, at *3:30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Prematurity*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY..... (Secondary)

(Signed) *J. R. Muller* M. D.  
*Jan 1, 1915* (Address) *137 W Lafayette Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *16 hrs* In the State *16 hrs* yrs. .... mos. .... ds.Where was disease contracted, if not at place of death? *L*Former or usual residence *L*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*M<sup>rs</sup> Carmel (Emily)* *Jan 2, 1915*

20-UNDERTAKER ADDRESS

*Arthur C. Fuller* *221 N Broadway*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE, (Name of street) ST. 7 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. 32 N. Elmwood Ave. St. — yrs. — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Sept 30th, 1914 (Month) (Day) (Year)

7-AGE,

3 yrs. — mos. — ds. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

child

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 2 - 1915

HARRY O. ANDREWS,

191.. Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec 31, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 1914, to Dec 31, 1914, that I saw him alive on Dec 31, 1914, and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH\* was as follows:

Malnutrition

CONTRIBUTORY (Secondary) (Duration) yrs. 2 mos. ds. Otitis Media; Cleft Palate

(Signed) G. A. Batten M. D.

Dec 31, 1914 (Address) 32 N. Elmwood Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 2 mos. ds. In the State yrs. 2 mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 32 N. Elmwood Ave.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Jan. 2, 1915

20-UNDERTAKER

ADDRESS

John A. Moran Ave. 14

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

C81546

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81546

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 6 WAR

2-FULL NAME

Residence in Baltimore: No.

Str. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the words)

6 DATE OF BIRTH

7 AGE

If LESS than day, hrs. min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JAN 2 - 1915

Filed, 191

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Dec 10, 1914, to Dec 31, 1914.  
that I saw her alive on Dec 31, 1914  
and that death occurred, on the date stated above, at 2:22 m.  
The CAUSE OF DEATH\* was as follows:

Myocarditis

Contributory (SECONDARY)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MANNER OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

C81547

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *2123 N. Saratoga* St.,

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Davenport*(Residence in Baltimore: No. *2123 N. Saratoga* St.;— yrs., — mos. *10* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*male*

## 4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)

## 6-DATE OF BIRTH,

*Dec 23*

(Month)

*23*

(Day)

*1914*

(Year)

## 7-AGE,

— yrs. — mos. *10* ds.

If LESS than 1 day,

— hrs. or — min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*

## 9-BIRTHPLACE,

(State or Country),

*Balto City*

## 10-NAME OF FATHER,

*James Davenport*

## 11-BIRTHPLACE OF FATHER (State or Country),

*North Carolina*

## 12-MAIDEN NAME OF MOTHER

*Mary Brickhouse*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*North Carolina*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Davenport*(Address) *2123 N. Saratoga*

## 15-

JAN 2 - 1915

HARRY O. ANDERSON,

Filed *191* Serial *Permit* Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Dec 1*

(Month)

(Day)

*1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 23* 1914, to *Jan 1* 1915, that I saw him alive on *Dec 31* 1914, and that death occurred, on the date stated above, at *10 A* m.

The CAUSE OF DEATH\* was as follows:

*Convulsions*

## CONTRIBUTORY

(Secondary)

*Cardiac*  
(Said) *James Davenport* M. D.  
*Jan 2*, 1915 (Address) *1778 N. Saratoga*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*London Park*

## DATE OF BURIAL,

*Jan. 2, 1915*

## 20-UNDERTAKER

*H. Brannington Son*

## ADDRESS

*517 N. Schroeder St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

081548

135

081548

### PLACE OF DEATH

CITY OF BALTIMORE (No. *809 S. Straper*)

ST. *1* WARD

2-FULL NAME *Sophia Wajer*

(Residence in Baltimore: No. *809 S. Straper St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. *19* mos. *12* ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH, *Unknown, 1899*

(Month)

(Day)

(Year)

7-AGE, *35*

yrs. *—* mos. *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE,

(State or Country), *Germany*

10-NAME OF FATHER, *Gregory Szulciewicz*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Mary Keyser*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Wajer*

(Address) *809 S. Straper*

15-*JAN 2 - 1915*

HARRY O. ANDREWS,

Filed *191* Serial *Permit* *Glary* Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec 31, 1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* find that said deceased came to *death* (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Uterine Hemorrhage*

(Duration) yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary) *Child Birth*

(Duration) yrs. *—* mos. *—* ds.

(Signed) *David W. Jones* M. D. (Coroner.)

*Dany 1, 1915* (Address) *3116 Odumwell St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. *—* mos. *—* ds. State yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus*

DATE OF BURIAL, *Jan 4, 1915*

20-UNDERTAKER, *M. F. Godowski*

ADDRESS *405 S. Ann St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1726 Mc Culloch* St.; *14* WARD)

## 2-FULL NAME

Residence in Baltimore: No. *1726 Mc Culloch* St.; *7* yrs., *7* mos. *7* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*Colored*

## 5-SINGLE,

*Infant*  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word.)

## 6-DATE OF BIRTH,

*June 4, 1914*  
(Month) (Day) (Year)

## 7-AGE,

*6 yrs. 7 mos. 7 ds.*If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),*Maryland*

## 10-NAME OF FATHER,

*Wm. Edw. Jackson*11-BIRTHPLACE OF FATHER  
(State or Country),*Md.*

## 12-MAIDEN NAME OF MOTHER

*Bertie Foster*13-BIRTHPLACE OF MOTHER  
(State or Country),*Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. Edw. Jackson*(Address) *1726 Mc Culloch*

## 15-

JAN 2 - 1915

Filed..... 191.....

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*December 31, 1914*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 30* 1914, to *Dec 31* 1914, that I saw her alive on *Dec, 31* 1914, and that death occurred, on the date stated above, at *1207* m.  
The CAUSE OF DEATH\* was as follows:*Marasmus and inanition*

## CONTRIBUTORY,

(Secondary) *Imperfect development of respiration & digestion*(Signed) *Edward Stolt* M. D.*Dec 31, 1914* (Address) *1812 Druid Heights*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Wt Auburn Cemetery, Jan 2, 1915*

## 20-UNDERTAKER

## ADDRESS

*John W. Henderson 307 N. Caroline*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81550

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81550

## 1-PLACE OF DEATH

CITY OF BALTIMORE (NO. *Union Protestant Infirmary* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Minnie Janne*(Residence in Baltimore: No. *522 South Boudin St., Highlandtown* St. *16* yrs. *7* mos. *?* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *May*, *1898*  
(Month) (Day) (Year)

7-AGE, *16* yrs. *7* mos. *?* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country), *Baltimore*

10-NAME OF FATHER, *Mrs. Janne*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Mrs. Janne*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. Chaff*(Address) *10 P.O.*

JAN 2 - 1915

HARRY O. ANDREWS,

Filed..... 1915 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Dec. 31*, *1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec. 11*, *1914*, to *Dec. 31*, *1914*, that I saw her alive on *Dec. 31*, *1914*, and that death occurred, on the date stated above, at *1:00 P. M.* The CAUSE OF DEATH\* was as follows:

*typhoid fever*  
(Duration)..... yrs. *1* mos. *?* ds.

CONTRIBUTORY *Peritonitis*  
(Secondary)  
(Duration)..... yrs. *5* mos. *?* ds.

(Signed) *Edwin L. Davis* M. D.  
*Dec. 31, 1914* (Address) *U. P. O.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death *U. P. O.* yrs. *21* mos. *21* ds. In the *16* yrs. *7* mos. *21* ds. State *16* yrs. *7* mos. *21* ds.

Where was disease contracted, if not at place of death? *522 S. Boudin St.*  
Former or usual residence *522 S. Boudin St. Baltimore*

19-PLACE OF BURIAL OR REMOVAL, *1st German* DATE OF BURIAL, *Jan. 3, 1915*

20-UNDERTAKER, *Peter Nicolaus* ADDRESS, *204 E. Eastern Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81551

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81551

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1310 N. Stanton*ST.: *15* WARD)

REGISTERED NO. C

## 2-FULL NAME

*Lillian Digg*

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

(Residence in Baltimore: No. *1310 N. Stanton*St.: yrs. *4* mos. *1* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX

*Female*

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*

6-DATE OF BIRTH,

*July 29, 1914*  
(Month) (Day) (Year)

7-AGE,

*5*  
yrs. *1* mos. *1* ds.

If LESS than 1 day, hrs. or mos. f

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*Child*

9-BIRTHPLACE, (State or Country),

*Balto, Md*

10-NAME OF FATHER,

*Samuel Digg*

11-BIRTHPLACE OF FATHER (State or Country)

*A. A. Co, Md*

12-MAIDEN NAME OF MOTHER

*Elizabeth Tyler*

13-BIRTHPLACE OF MOTHER (State or Country)

*A. A. Co. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Samuel Digg*

(Address)

*1310 N. Stanton St*

15-

JAN 2 - 1915

BARRY O. ANDREWS,

Filed 191... Serial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Dec 31st, 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec 29, 1914, to Dec 31, 1914,*that I saw her alive on *Dec 30, 1914,*and that death occurred, on the date stated above, at *9 A.* m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(Duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Harry P. Brown* M. D.*Dec 31, 1914* (Address) *1501 Preston*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Auburn**Jan 2, 1915*

20-UNDERTAKER

ADDRESS

*James H. Dinn* *1303 Preston*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81552

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81552

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs.; mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: *Male* 4-COLOR OR RACE: *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *—*

6-DATE OF BIRTH, *Nov 8, 1914*  
(Month) (Day) (Year)

7-AGE, *1* yrs. *25* mos. *—* ds. If LESS than 1 day. .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Infant*

## 9-BIRTHPLACE, (State or Country).

*Baltimore*

## 10-NAME OF FATHER,

*Albert Wigand*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Baltimore*

## 12-MAIDEN NAME OF MOTHER

*Anna Brown*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Baltimore*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Albert Wigand*

(Address)

*213 N. Bethel*

15-

JAN 2 - 1915

HARRY O. ANDERSON

FHE

191

Burial Permit No.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 1, 1915*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Dec 31, 1914* to *Jan 1, 1915* that I saw him alive on *Jan 1, 1915* and that death occurred on the date stated above, at *7:20 a.m.*

The CAUSE OF DEATH\* was as follows:

*Infantile Convulsions*

## CONTRIBUTORY (Secondary)

*Endeavour*

(Signed)

*W. J. Rogers*  
*1-2-15* (Address) *2008 G. Howard*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Oak Hill*

## DATE OF BURIAL,

*Jan 2, 1915*

## 20-UNDERTAKER

*Frank Crook & Son*

## ADDRESS

*1904 G. Howard Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

35 C81553  
REGISTERED NO. C

1 PLACE OF DEATH *Franklin Square Hoop.*

CITY OF BALTIMORE (No. *Calhoun & Fayette St* St. *19* WARD)

2 FULL NAME *Izora Stella Hobbs*

(Residence in Baltimore: No. *242 N. Mount* St. *35* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, *Single*  
~~MARRIED~~  
~~OR DIVORCED~~  
(If write the word)

6 DATE OF BIRTH *Apr - 20 - 1858*  
(Month) (Day) (Year)

7 AGE *56* yrs. *9* mos. *12* ds. or *12* mos. 1 day, hrs. min. ?  
If LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Seamstress*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Dress Maker*

9 BIRTHPLACE (State or country) *Cooksville, Howard Co. Md.*

10 NAME OF FATHER *Thos. B. Hobbs*

11 BIRTHPLACE OF FATHER (State or country) *Cooksville, Howard Co. Md.*

12 MAIDEN NAME OF MOTHER *Catherine Anne Hobbs*

13 BIRTHPLACE OF MOTHER (State or country) *Cooksville, Howard Co. Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elsie W. Hobbs per M. J.*

(Address) *242 N. Mount St.*

JAN 2 - 1915

BARRY U. ALLEN, JR.

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 1 - 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct - 1909* to *Jan 1 - 1915*, that I saw her alive on *Dec 31 - 1914*, and that death occurred, on the date stated above, at *430 A.M.* The CAUSE OF DEATH\* was as follows:

*Chronic Mitral Subulosis*

Contributory (SECONDARY) *Mitral Insufficiency*  
(Duration) *5* yrs. *2* mos. ds.

(Signed) *M. J. Funk* M. D.  
JAN - 1 1915 (Address) *1631 EUTAW PLACE, BALTIMORE, MD.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, *at home*  
If not at place of death?

Former or usual residence *242 N. Mount St. Balt. Md.*

19 PLACE OF BURIAL OR REMOVAL

*Burial Ridge*

DATE OF BURIAL

*Jan 3, 1915*

20 UNDERTAKER

*John Strickland 1200 N. Lombard*

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81554

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81554

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

yrs. e. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 2 - 1915

HARRY O. ANDREWS,

BAPTIST FORMER CLERK

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1914, to Jan 1, 1915, that I saw her alive on Jan 1, 1915, and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

Jan 1, 1915.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death? 148-8th St. (labor ad.)

Former or usual residence 148-8th St. (labor ad.)

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81555

## CERTIFICATE OF DEATH.

150 C81555  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. Ellwood Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 231 S. Ellwood Ave St. 1 yrs. 2 mos. 2 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Single

## 6-DATE OF BIRTH

Dec 31, 1914  
(Month) (Day) (Year)

## 7-AGE

2 yrs. 2 mos. 2 ds.

If LESS than 1 day,

2 hrs. or 2 min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).  
man9-BIRTHPLACE.  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry J. Wheathy(Address) 231 S. Ellwood Ave

## 15-

Filed

JAN 2 - 1915

HARRY O. ANDREWS

Burial Permit No. 015

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan, 2, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1914, to Jan 2 1915, that I saw him alive on Jan 1 1915, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)no cause of frame  
(Duration) 2 yrs. 2 mos. 2 ds.(Signed) W. J. M. D.

191... (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

W. J. M. D. Jan 2, 1915.

## 20-UNDERTAKER

## ADDRESS

W. J. M. D. 1700 E. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C81556

1-PLACE OF DEATH **Hahnemann General Hospital,**  
CITY OF BALTIMORE (No. **1122 N. Mount street,** ST. **15** WARD)  
2-FULL NAME **Marie C. Huggins,**  
3-Residence in Baltimore: No. **1906 Herbert street,** St.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX, <b>Female,</b>	4-COLOR OR RACE, <b>White,</b>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <b>Single.</b>
6-DATE OF BIRTH, <b>May 4th, 1910.</b> (Month) (Day) (Year)		
7-AGE, <b>4 yrs. 8 mos. 27 ds.</b>		If LESS than 1 day, ...hrs. or o...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <b>None.</b> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <b>Baltimore, Md.</b>		
PARENTS.	10-NAME OF FATHER, <b>Henry A. Huggins,</b>	
	11-BIRTHPLACE OF FATHER (State or Country), <b>Baltimore, Md.</b>	
	12-MAIDEN NAME OF MOTHER <b>Pearl Weber,</b>	
	13-BIRTHPLACE OF MOTHER (State or Country), <b>Baltimore, Md.</b>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) **Pearl Huggins,**  
(Address) **1906 Herbert street.**

15- **JAN 2 - 1915** **HARRY O. ANDREWS,**  
Filed....., 191... **Barial Permit Clerk**  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
**December 31st, 1914.**  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said **inquiry** find that said deceased came to **her** death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
**Burns of the upper half of body accidentally received from kitchen stove.** (Duration) ... yrs. ... mos. ... ds.  
CONTRIBUTORY **Pneumonitis traumatica,** (Secondary) (Duration) ... yrs. ... mos. ... ds.  
(Signed) **J. Frederick Hennig** M. D. (Coroner.)  
**Jan. 2nd, 1914.** (Address) **1103 Valley st.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death? **1906 Herbert street**  
Former or usual residence **1906 Herbert St.**

19-PLACE OF BURIAL OR REMOVAL, **Western Cem** DATE OF BURIAL, **Jan. 2, 1915**  
20-UNDERTAKER, **Samuel Easton** ADDRESS **916**  
**Brima ave**



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81557 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 509 S. Hanover -

ST. 22

WARD

2-FULL NAME

John Aloysius Carroll

(Residence in Baltimore: No. 509 S. Hanover

St. 5 yrs. 5 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

July 6, 1909

7-AGE

5 yrs. 5 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE (State or country)

Balto.

10-NAME OF FATHER

Martin J. Carroll

11-BIRTHPLACE OF FATHER (State or country)

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Mary Mulcahy

13-BIRTHPLACE OF MOTHER (State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mortimer Sales

(Address)

509 S. Hanover St.

15-

JAN 2 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 1, 1915

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 12, 1914, to Jan 1, 1915

that I saw him alive on Dec. 30, 1914

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH\* was as follows:

Hereditary Syphilis

Contributory (SECONDARY)

(Duration) 3 yrs. 4 mos. 4 ds.

Broncho Pneumonia

(Signed)

John S. Bishop M. D.

Jan 1, 1915 (Address) 828 N. Carrollton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

1047 Hollman St.

19-PLACE OF BURIAL OR REMOVAL

H. Peters

DATE OF BURIAL

Jan 3, 1915

20-UNDERTAKER

Wm. Gauthier

ADDRESS

201 W. North Ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81558

C81558

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-JAN 2 - 1915

MARET O. ANDERSON

Burial Permit Clerk

Filed..... 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-27-1914, to 12-29-1914, that I saw him alive on 12-29-1914, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic  
Purulent Nephritis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

12-29-1914 (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 2 mos. 2 ds. Is the 39 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4 Weisenfeld Court

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

1-3-1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81559

## CERTIFICATE OF DEATH.

C81559

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 E. Madison ST.) 7 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1702 E. Madison

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

Black

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

(Write the word.) Single

## 6-DATE OF BIRTH,

December 30, 1914.  
(Month) (Day) (Year)

## 7-AGE.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country).

## 10-NAME OF FATHER.

## 11-BIRTHPLACE OF FATHER (State or Country).

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....  
(Address).....

## 15-

JAN 2 - 1915

BARRY O. JOHNS

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

December 31, 1914.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30 1914, to Dec. 30 1914, that I saw her alive on Dec. 30 1914, and that death occurred, on the date stated above, at 10:30 am.

The CAUSE OF DEATH\* was as follows:

Premature labor

## CONTRIBUTORY (Secondary)

(Signed) J. H. Wilson M. D.  
Dec. 31, 1914. (Address) 23 W. and Chase St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

## DATE OF BURIAL,

12-31, 1914

## 20-UNDERTAKER

## ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-14—M. & T.—500 Bks.

C81560

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *424 E. 20th St.* ST. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Anna Clara Nordoyt.*

(Residence in Baltimore: No. *424 E. 20th St.* St.: yrs. mos. ds.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*  
(Write the word.)

6-DATE OF BIRTH, *September 3<sup>rd</sup>, 1847*

(Month) (Day) (Year)

7-AGE, *67* yrs. *3* mos. *28* ds.

IF LESS than 1 day,  
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*

9-BIRTHPLACE, (State or Country), *Balt. Md.*

10-NAME OF FATHER, *Jacob Beiswanger*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. August Nordoyt*

(Address) *424 E. 20th St.*

15-

*JAN 2 - 1915*

*HARRY O. ANDREWS,*

Filed

191

*Burial Permit Clerk.*  
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec. 24, 1914*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec. 24, 1914*, to *Dec. 31, 1914*,

that I saw him alive on " " 1914,

and that death occurred, on the date stated above, at *2:10 P.m.*

The CAUSE OF DEATH\* was as follows:

*Ac. Grippe 5 days*

(Duration) yrs. mos. ds.

CONTRIBUTORY *Bronchial pneumonia*

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Dr. J. H. Hartman* M. D.

*Aug. 2, 1915* (Address) *1121 E. 20th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*

DATE OF BURIAL, *Jan. 2, 1915*

20-UNDERTAKER

*George Schilling & Son 1126 E. 20th St.*

ADDRESS

57 m  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81561

## HEALTH DEPARTMENT-CITY OF BALTIMORE

C81561

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 524 N. Pulaski St. 20 WARD)

2. FULL NAME

Residence in Baltimore: No.

St.; yrs. 1 mos. 5 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
Write the word

6. DATE OF BIRTH

7. AGE

If LESS than

1 day, --- hrs.

yrs. 1 mos. 5 ds. or --- min.?

8. OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9. BIRTHPLACE

(State or country)

10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER  
(State or country)12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER  
(State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed), M. D.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,  
or Recent Residents)

At place of death yrs. mos. ds. In the

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

JAN 2 - 1915

Filed

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

81

081562

PLACE OF DEATH

CITY OF BALTIMORE

No. 1427 W. Lafayette Ave.

St. 16 WARD

FULL NAME

George W. Russell

(Residence in Baltimore: No. 1427 W. Lafayette Ave.

St. 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male 2 COLOR OR RACE White 3 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

4 DATE OF BIRTH August 13, 1840 (Month) (Day) (Year)

5 AGE 74 yrs. 4 mos. 17 ds. or min. 7 If LESS than 1 day, hrs.

6 OCCUPATION (a) Trade, profession, or particular kind of work Cigar packer (b) General nature of industry, business, or establishment in which employed (or employer)

7 BIRTHPLACE (State or country) Maryland

8 NAME OF FATHER Richard B. Russell

9 BIRTHPLACE OF FATHER Md.

10 MAIDEN NAME OF MOTHER Louisa Graham

11 BIRTHPLACE OF MOTHER Del.

12 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Russell

(Address) 1424 W. Lafayette Ave.

13 HARRY O. ANDREWS, Registrar

Filed JAN 2 - 1915

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from November 20, 1914 to Jan 1, 1915 that I saw him alive on Jan 1, 1915 and that death occurred, on the date stated above, at 5 a. m. The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis.

Contributory (SECONDARY) Acute Enteritis (Duration) 4 yrs. mos. ds.

(Signed) Stephen Steelman M. D. (Address) 1227 W. Lafayette Ave. (Duration) 3 yrs. mos. ds.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Western

DATE OF BURIAL Jan 4, 1915

20 UNDERTAKER

Geo. W. Little

ADDRESS

531 N. Fremont

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81563

C81563

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John H. Hoop* ST.; *7* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Bamberg S.C.*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX

*male*

## 3-COLOR OR RACE

*white*4-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 5-DATE OF BIRTH

*Apr**22*, 1876

(Month)

(Day)

(Year)

## 7-AGE

*40* yrs. *8* mos. *10* da.

If LESS than 1 day.

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Merchant*

## 9-BIRTHPLACE,

(State or Country),

*South Carolina*

## 10-NAME OF FATHER,

*J. B. Hunter*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*S.C.*

## 12-MAIDEN NAME OF MOTHER

*Eliz. Fowler*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*S.C.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*A. B. Curry*

(Address)

*J. H. Hoop*

## 15-

Filed

*JAN 2 1915*

191

HARRY O. ANDREWS,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan**2*

1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 31* 1914, to *Jan 2* 1915that I saw him alive on *Jan 2* 1915and that death occurred, on the date stated above, at *4:15* p.m.

The CAUSE OF DEATH\* was as follows:

*Acute Pulmonary Edema*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) *Acute Mitral Insufficiency* ds.(Signed) *G. B. H. H. H.* M. D.*Jan 2*, 1915 (Address) *J. H. Hoop*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *2* ds. In the State yrs. mos. *2* ds.Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence

*Bamberg S.C.*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Denmark S.C.**Jan 3*, 1915

## 20-UNDERTAKER

## ADDRESS

*W. H. E. Fuller**321 N. Broadway*

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81564

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81564

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3613 Elm Ave.

ST.: 13 WARD)

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

John H. Sheffer

(Residence in Baltimore: No.

3613 Elm Ave.

St.: 10 yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

June

23

1882

(Month)

(Day)

(Year)

7-AGE,

32

6

8

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Electrician

9-BIRTHPLACE, (State or Country),

Penna.

10-NAME OF FATHER,

Jeremiah Sheffer

11-BIRTHPLACE OF FATHER (State or Country),

Penna.

12-MAIDEN NAME OF MOTHER

Barbara C. Kerchner

13-BIRTHPLACE OF MOTHER (State or Country),

Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Barbara Sheffer

(Address)

York, Pa.

15-JAN 2 - 1915

HARRY O. ANDREWS,

Berial Permit Clerk

Filed..... 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec

31

1914

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17, 1914, to Dec 31, 1914, that I saw him alive on Dec 31, 1914, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH\* was as follows:

Tapped and severe complications by lobar pneumonia

(Duration)..... yrs. .... mos. 19 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed) J. H. Andrews, M. D.

Dec 31, 1914 (Address) 846 W 36 St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Brimd Ridge

Jan 3, 1915

20-UNDERTAKER

ADDRESS

Horace Burge &amp; Son 3631 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1044 Ligth St

ST.: 23

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Sewell

(Residence in Baltimore: No. 1044 Light St

St.; yrs., 64 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Dec 9, 1850 (Month) (Day) (Year)

7-AGE, 64 yrs. 23 ds. If LESS than 1 day, hrs. nr. min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Plaster (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland.

10-NAME OF FATHER, John F. Sewell

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Rachel S. Law.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Byron E. Sewell

(Address) 824 N. 34th St.

15- JAN 2 - 1915. HARRY O. ANDREWS, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Nephritis Acute

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edgar S. Sweeney M. D. (Coroner.)

Dec 1 5 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Md.

DATE OF BURIAL, Jan 3, 1915

20-UNDERTAKER, Grace Bungee Son

ADDRESS, 363 Falls Road



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *513 Hargrove Alley* St. *11*)

WAID)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

*Philip Shepherd*

(Residence in Baltimore: No. *513 Hargrove Alley*)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Single</i>
6-DATE OF BIRTH, <i>November 26, 1875</i> (Month) (Day) (Year)		
7-AGE, <i>39</i> yrs. <i>1</i> mos. <i>5</i> ds. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <i>Hotel Porter</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE,  
(State or Country),

*City*

PARENTS.	10-NAME OF FATHER, <i>Philip Shepherd</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>City</i>
	12-MAIDEN NAME OF MOTHER <i>Mary E. Sappington</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>City</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Digger (Sister)*

(Address) *513 Hargrove Alley*

15 JAN 2 - 1915 HARRY O. ANDREWS, Registrar.

Filed....., 191... Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
*December 31, 1914*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* and that said deceased came to *death* (Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acute cardiac dilatation*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Nephritis*

(Duration)..... yrs. .... mos. .... ds.

(Signed) *E. H. Chambers* M. D.  
(Coroner.)

*Jan. 1, 1915* (Address) *18 N. Paulina St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery*

DATE OF BURIAL, *Jan. 4, 1915*

20-UNDERTAKER *McGinnis & Carroll*

ADDRESS *608 N. Paulina St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 5-19-12 M. & T.—500 Bks.

81567

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

28 C81567

### PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Nanticoke

ST.: 21 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

### FULL NAME

Ida Kloffke

(Residence in Baltimore: No. 1022 Nanticoke

St.: 14 yrs., mos. ds)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 2-SEX,

Female

#### 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single  
(Write the word.)

#### 6-DATE OF BIRTH,

April 16, 1895  
(Month) (Day) (Year)

#### 7-AGE,

19 yrs. 8 mos. 15 ds.

If LESS than 1 day.  
hrs. or min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

#### 9-BIRTHPLACE, (State or Country),

Virginia

#### 10-NAME OF FATHER,

Charles F Kloffke

#### 11-BIRTHPLACE OF FATHER (State or Country),

Germany

#### 12-MAIDEN NAME OF MOTHER

Annie Vitezkie

#### 13-BIRTHPLACE OF MOTHER (State or Country),

Germany

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kloffke

(Address) 1122 Nanticoke St.

15- JAN 2 - 1915

HARRY O. ANDREWS,

Filed 1915 Burial Permit Clerk Registrar.

### MEDICAL CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

Dec 31, 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1914, to Dec 31 1914, that I saw her alive on Dec 31 1914, and that death occurred, on the date stated above, at 9.15 p. The CAUSE OF DEATH\* was as follows:

Phtiaia (Pulmonary)

(Duration) 4 mos. 12 ds.

#### CONTRIBUTORY (Secondary) Exhaustion

(Duration) 6 mos. 6 ds.

(Signed) M. D.

Jan 2, 1915 (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Cemetery Jan 3, 1915

#### 20-UNDERTAKER

George Smith Address 2150

C81568

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Orleans St. 10 WARD)

2-FULL NAME Margaret Gustus

Residence in Baltimore: No. 1414 Orleans St.; 62 yrs. 2 mos. 27 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-MARRIAGE STATUS  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

Oct 3 1852  
(Month) (Day) (Year)

7-AGE

62 yrs. 2 mos. 27 ds. or min.?  
If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9-BIRTHPLACE  
(State or country)

Baltimore

10-NAME OF FATHER

Christopher Bair

11-BIRTHPLACE OF FATHER  
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER  
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Gustus  
1414 Orleans St.

15-

Filed

JAN 2 - 1915

HARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Dec 31 1914  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1914, to Dec 31 1914, that I saw her alive on Dec 31 1914, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH\* was as follows:

Asthmatic Complications  
of pneumoniaContributory  
(SECONDARY)(Duration) yrs. mos. ds.  
Contributory: pneumonia (Duration) yrs. mos. ds. 16  
(Signed) J. H. Schuchman M.D.  
Jan 1 1915 (Address) 1228 Charles St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted.  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore

Jan 4 1915

20-UNDERTAKER

ADDRESS

J. H. Schuchman

2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81569

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81569

1 PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1351 Ocean Ave. ST. 13)

2-FULL NAME, Harry J. Bankard

(Residence in Baltimore: No. 1301 Ocean Ave. 33)

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 18.)

33 yrs. 6 mos. 6 ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

(Write the word)

Married

6-DATE OF BIRTH

June

27, 1881

7-AGE

33

6 mos. 6 ds.

If LESS than 1 day, hrs., or min.

8-OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

9-BIRTHPLACE

(State or country)

Md.

10-NAME OF FATHER

Wesley H. Bankard

11-BIRTHPLACE OF FATHER

(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Annie M. Joynt

13-BIRTHPLACE OF MOTHER

(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter H. Bankard

(Address)

1810 N. Monroe St.

JAN 2 - 1915

FILED

491

HARPER O. ALDER

Bureau Permit Officer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January

(Month)

(Day)

1915

I HEREBY CERTIFY, That I attended deceased from

Mr. H. Bankard, to January 21, 1915,

that I saw him alive on January 21, 1915,

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia

Contributory (SECONDARY)

(Signed)

Wm. H. Bankard, M.D.

20, 1915 [Address] 2101 N. Ocean Ave.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

Roadhouse

DATE OF BURIAL

Jan 3, 1915

UNDERTAKER

George J. Smith

ADDRESS

1810 N. Monroe St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81570

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (Name)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 5 yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 3 - 1915

101

BARRY O. ANDREWS,

Sanitary Permit 0156

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Dec 21 1914 to Jan 2 1915

that I saw him alive on Jan 2 1915

and that death occurred, on the date stated above, at 2:35 p.m.

The CAUSE OF DEATH\* was as follows:

Metastatic carcinoma

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hoepf M. D.

Jan 2, 1915 (Address) J. H. Hoepf

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 910 E. Pratt St

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Hehrer Mt. Carmel Road Jan 3, 1915

20-UNDERTAKER

ADDRESS

Jack Lewis

1419 E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81571

## HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. *226 Calver*)

FULL NAME

(Residence in Baltimore: No. *226 Calver*)ST. *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *—* yrs., *0* mos., *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*Oct 4**1887*

7-AGE,

*27* yrs., *2* mos., *28* ds.If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) *Labour*9-BIRTHPLACE, (State or Country), *N. C.*10-NAME OF FATHER, *Seth Royce*11-BIRTHPLACE OF FATHER (State or Country), *N. C.*12-MAIDEN NAME OF MOTHER *Mazie Doney*13-BIRTHPLACE OF MOTHER (State or Country), *N. C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Royce*(Address) *226 Calver*

15-

Filed.

JAN 3 - 1915

HARRY G. ANDERSON

Barial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 2*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 29* 1914, to *Jan 2* 1915, that I saw h alive on *Jan 2* 1915, and that death occurred, on the date stated above, at *11408* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary phthisis*(Duration) *2* yrs., *2* mos., *14* ds.CONTRIBUTORY (Secondary) *Cardiac asthenia*(Duration) *2* yrs., *2* mos., *14* ds.(Signed) *H. G. Anderson* M. D.*Jan 2*, 1915. (Address) *11408*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* ds. In the *—* State *—* yrs., *—* mos., *—* ds.Where was disease contracted, if not at place of death? *—*Former or usual residence *—*19-PLACE OF BURIAL OR REMOVAL, *Burgilina Va*DATE OF BURIAL, *Jan 3*, 191520-UNDERTAKER *W. J. Jackson*ADDRESS *1409 Mullikin*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81572

## CERTIFICATE OF DEATH

REGISTERED No. C

64 C81572

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2944 Cedar Ave. ST. 13 WARD)

2-FULL NAME Harry S. Gardiner

Residence in Baltimore: No. 2944 Cedar Ave. St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH June 12 / 1873 (Month) Day (Year)

7-AGE 41 yrs. 6 mos. 19 ds. If LESS than 1 day hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Lawyer (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore City Md.

10-NAME OF FATHER John Gardiner

11-BIRTHPLACE OF FATHER (State or country) Baltimore City Md.

12-MAIDEN NAME OF MOTHER Farley

13-BIRTHPLACE OF MOTHER (State or country) Baltimore City Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie Gardiner

(Address) 2944 Cedar Ave.

15-

JAN 3 - 1915

Serial Permit 0151

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH Dec 31 1914 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 26 1914, to, December 31 1914, that I saw him alive on December 31 1914, and that death occurred, on the date stated above, at 8:30 AM.

THE CAUSE OF DEATH\* was as follows:

Apoplexy.

Contributory (SECONDARY)

(Signed) A. J. Jones M. D. Jan 2 1915 (Address) 800 W 33rd St

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER

ADDRESS



## C81573 HEALTH DEPARTMENT—CITY OF BALTIMORE

C81573

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

644 W. Banne St.

REGISTERED NO. C

CITY OF BALTIMORE: (NO.

ST. (.....) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William J. White

(Residence in Baltimore: No.

644 W. Banne St.

St.: ..... yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male White

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Nov. 2, 1885

7-AGE,

69 yrs. 1 mos. 29 ds.

If LESS than 1 day,

.... hrs. or .... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Tinner

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 3 - 1915

Filed

1915

HARRY O. ANDERSON

SPECIAL PERMIT

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Dec. 1, 1915

17-

I HEREBY CERTIFY, That I attended deceased from

Dec. 27, 1914 to Jan. 1, 1915

that I saw him alive on Dec. 1, 1915

and that death occurred, on the date stated above at 10 A.M.

The CAUSE OF DEATH\* was as follows:

Inflammation of Lungs  
Pneumonia  
(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) M. D.

Jan. 2, 1915 (Address) W. A. Lumbard Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? 644 W. Banne St.

Former or usual residence 644 W. Banne St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wheatland Cemetery Jan. 3, 1915

20-UNDERTAKER

ADDRESS

Wm. J. Lumbard, 1000 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1412 Light St.*)

## 2-FULL NAME

(Residence in Baltimore: No. *1705 Jefferson St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE

MARRIED

*Married*  
(Write the word.)

6-DATE OF BIRTH,

*Unknown*  
(Month) (Day) (Year)

7-AGE

*About 57 years*

IF LESS than 1 day

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),*Baltimore City*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Margaret Anne Russell*

(Address)

*1705 Jefferson St.*

15-

JAN 3 - 1915

191

BARRY O. ANDERSON

Barral Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 1, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Oct. 20, 1914, to Jan. 1, 1915*that I saw him alive on *Dec. 5, 1914*and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis of Lung*  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*W. H. Russell* M. D.*Jan. 2, 1915* (Address) *1412 Light St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Hill**Jan. 4, 1915*

20-UNDERTAKER

ADDRESS

*W. H. Russell**5026 Hill*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81575

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81575

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1316 Steever St.* ST. *9*)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. *1316 Steever St.*

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.) *Widow*

## 6-DATE OF BIRTH

*Sept 3* (Month) *3* (Day) *1881* (Year)

## 7-AGE

*83* yrs. *4* mos. ds. IT LESS than 1 day. hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*at Home*9-BIRTHPLACE,  
(State or Country),*Md.*

## 10-NAME OF FATHER

*Lamuel Seolugen*11-BIRTHPLACE OF FATHER  
(State or Country),*Island.*

## 12-MAIDEN NAME OF MOTHER

*Lois Krum*13-BIRTHPLACE OF MOTHER  
(State or Country),*Island.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mellie L. Evans*(Address) *1425 Carnegie St.*

15- JAN 3 - 1915

HARRY O. ANDREWS,

Filed..... 191... Serial Permit. Olor Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*January 2nd*, 1915.  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Dec. 5th* 1914 to *Jan. 2nd* 1915, that I saw her alive on *Jan. 2nd* 1915, and that death occurred, on the date stated above, at *2 P.m.*

## The CAUSE OF DEATH\* was as follows:

*Marionary Cancer*  
*diagnosed*  
(Duration) *1* yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Signed) *J. B. Schwartz* M. D.  
*Jan. 2* 1915 (Address) *822 W. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

*Baltimore*

## DATE OF BURIAL

*Jan. 4*, 1915

## 20-UNDERTAKER

*William Cook*

## ADDRESS

*502 E. 10th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81570

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2631 N. Charles* ST.; *12* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *2631 N. Charles* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED.  
(Write the word.) *Widow*

## 6-DATE OF BIRTH.

*November, 1837*  
(Month) (Day) (Year)

## 7-AGE.

*78* yrs., mos. ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,  
(State or Country).*Md.*

## 10-NAME OF FATHER,

*J. Austin Wheeler*

## 11-BIRTHPLACE OF FATHER

(State or Country).

*Md.*

## 12-MAIDEN NAME OF MOTHER

*Henrietta Green*

## 13-BIRTHPLACE OF MOTHER

(State or Country).

*Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs. Maria Cooper*(Address) *2631 N. Charles St.*

## 15-

Filed

*JAN 3 - 1915*

HARRY O. ANDREWS

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 1st, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 10, 1914*, to *Jan 1, 1915*, that I saw *her* alive on *Jan 1, 1915*, and that death occurred, on the date stated above, at *11:30 a.m.*  
The CAUSE OF DEATH\* was as follows:  
*Cerebral Hemorrhage*  
(Duration) yrs. *one* mos. ds.CONTRIBUTORY  
(Secondary)*paralysis*  
(Duration) yrs. *one* mos. ds.

(Signed)

*J. W. Adams* M. D.1915 (Address) *118 S. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

*Cathedral City* *Jan 4, 1915*

## 20-UNDERTAKER

## ADDRESS

*Chas. F. Brown 118 W. North Royal Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81577

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 2426 E Lafayette Ave ST.)

2-FULL NAME

Thomas R Ramsey  
Residence in Baltimore: No. 2426 E Lafayette Ave

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6-DATE OF BIRTH

Feb 21<sup>st</sup> 1874  
(Month) (Day) (Year)

7-AGE

40 yrs. 10 mos. 10 ds.  
If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Police

9-BIRTHPLACE (State or Country).

Md.

10-NAME OF FATHER

Mortimer Ramsey

11-BIRTHPLACE OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Charlotte Williams

13-BIRTHPLACE OF MOTHER (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 3 - 1915

Filed 191

HARRY O. ARLETT, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 1<sup>st</sup> 1915  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Pulmonary Hemorrhage  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) Elisha L. Russell, M. D. (Coroner)  
Jan 1<sup>st</sup> 1915 (Address) 423 N. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery Jan 4<sup>th</sup> 1915

20-UNDERTAKER

Chas. J. Evans 118 W. Mt. Royal Ave

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81578

C81578

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. 10

WARD)

2-FULL NAME

Mary Anne Schlinbach

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

Little Sisters of the Poor

St. 60

yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

Dec

26, 1915

(Month)

(Day)

(Year)

7-AGE

86

yrs.

mos.

ds.

If LESS than  
1 day, hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE  
(State or country)

Germany

PARENTS

10-NAME OF FATHER

George Schenard

11-BIRTHPLACE OF FATHER  
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Mary Grubel

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Benusiet

(Address) Little Sisters of the Poor

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 4

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to record

191

to,

191

that I saw h. *en* alive on

Dec 31

1915

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Cerebral apoplexy

1 week

(Duration)

yrs.

mos.

ds.

Contributory  
(SECONDARY)

Coma

(Duration)

yrs.

mos.

ds.

(Signed),

J. H. Barner

M. D.

1915

[Address]

1133 Valley St

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

8 yrs.

3 mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Little Sisters of the Poor

Former or usual residence

Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

1 - 4

1915

20-UNDERTAKER

E. B. Harle

ADDRESS

115 E Mead St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 3 - 1915

Filed 191

HARRY O. ANDREWS,  
Berial Permit Clerk  
REGISTRAR



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C81579

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2755 Edmondson Ave. ST. 70

WARD)

2-FULL NAME

Susan H. Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

Residence in Baltimore: No.

2755 Edmondson Ave.

St.:

yrs.

3

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widow

6-DATE OF BIRTH

November 5, 1857

(Month)

(Day)

(Year)

7-AGE

57 yrs. 1 mos. 28 ds.

If LESS than  
1 day, hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

None

9-BIRTHPLACE

(State or country)

King & Queen's Co. Va.

10-NAME OF FATHER

Robert Anderson

11-BIRTHPLACE OF FATHER

(State or country)

Virginia

12-MAIDEN NAME OF MOTHER

Emma H. Sears

13-BIRTHPLACE OF MOTHER

(State or country)

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Jackson

(Address)

2755 Edmondson Ave.

15-JAN 3 - 1915

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 2, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Nov. 29, 1914, to Jan 2, 1915.

that I saw her alive on Jan 2, 1915.

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH\* was as follows:

Exhaustion

Contributory  
(SECONDARY)

Organic Heart Disease

(Signed),

Paul Brown, M. D.

Jan 2, 1915 (Address) 1837 Penn. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

West Point Va.

DATE OF BURIAL

Jan 4, 1915

20-UNDERTAKER

Geo. W. Little

ADDRESS

531 A Fremont Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

C81580

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Brookfield Ave ST. 13 WARD)

2-FULL NAME Flora D. Cotton

(Residence in Baltimore: No. 2117 Brookfield Ave St. 30 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH Dec. 5 1854  
(Month) (Day) (Year)

7-AGE 60 yrs. 0 mos. 26 ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work At home  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) St Mary's Co. Md.

10-NAME OF FATHER Thomas Bennett

11-BIRTHPLACE OF FATHER (State or country) St. Mary's Co. Md.

12-MAIDEN NAME OF MOTHER Thomas

13-BIRTHPLACE OF MOTHER (State or country) St. Mary's Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Tetts

(Address) 1309 Calvert Bldg.

15 JAN 3 - 1915

HAROLD O. ANDREWS

Marial Permit Clerk

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan. 1 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 6 - 1909, to Jan 1 1915,

that I saw her alive on Jan 1 1915,

and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH\* was as follows:

Atrophic Cirrhosis

(Duration) 5 yrs. 10 mos. 25 ds.

Contributory (SECONDARY) Ascites

(Duration) 7 yrs. mos. ds.

(Signed) F. N. Tamm M. D.

Jan. 2 1915. [Address] 317 N. Carrollton

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yr. mos. ds. State yr. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge Cemetery

Jan 4 1915

20-UNDERTAKER

ADDRESS

Henry W. Meun & Son

805 N. Calvert St.

## C81581 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81581

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *167*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. *7612*St. *30* yrs. *8* mos. *8* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(If married, give date of death of spouse.)

## 6-DATE OF BIRTH

*Unknown* *1*

(Month)

(Day)

(Year)

## 7-AGE

*31* yrs. *8* mos. *8* ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housework*9-BIRTHPLACE,  
(State or Country),*New York*

## 10-NAME OF FATHER

*Joseph Weber*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Rosa Hansen*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. Weber*(Address) *612 Disquith St.*

JAN 3 - 1915

HARRY O. ALLEN

Filed *191* Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 1*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 29* 1914, to *Jan 1* 1915, that I saw her alive on *Jan 1* 1915, and that death occurred, on the date stated above, at *7 P.M.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(Duration) *7* yrs. *8* mos. *8* ds.

## CONTRIBUTORY

(Secondary)

*Accidental* *asphyxiation* *from turning part of body*(Signed) *Chas. C. Apples* M. D.*Jan 1*, 1915 (Address) *Ind. Gen. Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs. *8* mos. *8* ds. In the *30* yrs. *8* mos. *8* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *612 Disquith St.*

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Blair Rd**Jan 3*

## 20-UNDERTAKER

## ADDRESS

*S. Lenson Bro**Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81582

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

C81582

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 8 north west

6 WARD)

2-FULL NAME

Wolf Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 80 n. Wolfe Street

St. 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

Jan

1862

7-AGE

53

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

9-BIRTHPLACE (State or country)

Russia

10-NAME OF FATHER

David Miller

11-BIRTHPLACE OF FATHER (State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lewis

(Address)

1419 E. Balt St

JAN 3 - 1915

MARY O. ANDREWS,

Filed

191

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January

2

1915

17. I HEREBY CERTIFY, That I attended deceased from

1907, 191, to Jan 2, 1915.

that I saw him alive on Jan 2, 1915.

and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH\* was as follows:

Parasitosis, tuberculous  
lobes, becoming general with  
abscesses - tuberculous hemorrhages  
myocarditis (Duration) 7 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Robert H. Smith

M. D.

191 (Address) 1126 E. Baltimore St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Herrin

DATE OF BURIAL

Jan 3, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Balt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81583

## CERTIFICATE OF DEATH.

REGISTERED No. C

C81583

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1430 Andre St

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Cornelius Deasy

(Residence in Baltimore: No. 1430 Andre St

St. 35 yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, Male 2-COLOR OR RACE, White 3-SINGLE, MARRIED, Married (Write the word.)

4-DATE OF BIRTH, Unknown 5-AGE, 57 yrs., mos. ds. If LESS than 1 day, hrs. or min.?

6-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

7-BIRTHPLACE, (State or Country), Ireland

8-NAME OF FATHER, Michael Deasy

9-BIRTHPLACE OF FATHER, Ireland

10-MAIDEN NAME OF MOTHER, Catherine Hayes

11-BIRTHPLACE OF MOTHER, Ireland

12-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Deasy

(Address) 1430 Andre St

13-JAN 3 - 1915 HARRY O. ANDREWS,

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

14-DATE OF DEATH, Jan 1, 1915 (Month) (Day) (Year)

15-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, au-

topsy or inquiry.) And that said deceased came to His death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Nephritis Chronic (Duration) yrs. Sudden ds.

CONTRIBUTORY (Secondary)

(Signed) Edw. J. M. D. (Coroner)

Jan 2, 1915 (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

17-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan 4, 1915

18-UNDERTAKER, D. J. M. J. J. J.

ADDRESS, 1430 Andre St

14. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

C81584

## CERTIFICATE OF DEATH

C81584

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 1829 Covington St. ST. 24 WARD)

2-FULL NAME

Sarah Brophy

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1829 Covington St. St. 40 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widow

6-DATE OF BIRTH

April

1849

7-AGE

65 yrs. 8 mos. ds. or min.?

If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE  
(State or country)

Ireland

PARENTS

10-NAME OF FATHER

James King

11-BIRTHPLACE OF FATHER  
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Stafford

13-BIRTHPLACE OF MOTHER  
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catherine Deasy

(Address)

529 Covington St.

15-

JAN 3 - 1915

HARRY O. ANDREWS,  
Berial Permit Officer  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan. 2nd., 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1913, to Jan. 1st. 1915, that I saw her live on Jan. 1st. 1915, and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH\* was as follows:

chronic interstitial nephritis

(Duration) 2 or 3 yrs. mos. ds.

Contributory (SECONDARY) senile dementia

(Duration) 1 yrs. mos. ds.

(Signed) Philip B. Towner, M.D.

Jan. 2nd., 1915 [Address] 1432 William St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Jan. 2nd., 1915

20-UNDERTAKER

Dr. M. J. Flynn

ADDRESS

1422 Light St.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81585

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81585

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 5228 Bethel

ST.

WARD

2-FULL NAME Stanislaus Malichowski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 522 S. Bethel

St.

Yrs.

mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

April 11, 1914

(Month) (Day) (Year)

7-AGE

If LESS than

1 day, hrs.,

Yrs. 8 mos. 22 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Child.

9-BIRTHPLACE

(State or country)

Baltimore, Md.

10-NAME OF FATHER

John Malichowski

11-BIRTHPLACE OF FATHER  
(State or country)

Austria Poland

12-MAIDEN NAME OF MOTHER

Katherine G. Gling

13-BIRTHPLACE OF MOTHER  
(State or country)

Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Malichowski

(Address)

522 S. Bethel St

15-

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 21, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 29, 1914, to Jan 21, 1915,

that I saw him alive on Jan 12, 1915,

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH\* was as follows:

Laryngismus Stridulus

Contributory (SECONDARY)

Convulsion

(Signed)

Jan 21, 1915

(Address)

100 S. Patterson St

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stanislaus

Jan 4, 1915

20-UNDERTAKER

ADDRESS

M. F. Sadowski

405 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81586

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3825 Hickory St. 13 WARD)

2-FULL NAME Mary C. Beach

(Residence in Baltimore: No. 3825 Hickory St.; 13 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

WIDOWED

Widow

(Write the word)

6-DATE OF BIRTH

Unknown 1915

(Month)

(Day)

(Year)

7-AGE

63 yrs. 6 mos. 0 ds.

If LESS than

1 day, 0 hrs. 0 min.

8-OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Virginia

10-NAME OF FATHER

Redman Mills

11-BIRTHPLACE OF FATHER

(State or country)

Va

12-MAIDEN NAME OF MOTHER

Margaret Reid

13-BIRTHPLACE OF MOTHER

(State or country)

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Milton Reid

(Address)

3826 Hickory Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 2 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

May 10, 1914, to, Jan 2 1915,

that I saw her alive on January 1 1915,

and that death occurred, on the date stated above, at 9-10 m.

The CAUSE OF DEATH\* was as follows:

Cancer of Stomach

(Duration)

1 yrs. 2 mos. 0 ds.

Contributory (SECONDARY)

(Duration)

0 yrs. 0 mos. 0 ds.

(Signed)

J. J. Shelley

M. D.

[Address] 1849 Polansky

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death

0 yrs. 0 mos. 0 ds.

in the

0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Occoquan Va

Jan 4 1915

20-UNDERTAKER

ADDRESS

Milton E. Gosnell

705 W 37th St

JAN 3 - 1915

Filed

191

Barial Permit Clerk

REGISTRAR

C81587

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81587

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincents Inf. Asy.* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Jerome Duke*(Residence in Baltimore: No. *St. Vincents Infant Asylum* St.: yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*  
(Write the word.)6-DATE OF BIRTH, *Nov. 21st, 1914*

(Month)

(Day)

(Year)

7-AGE, *1 mos. 15 da.*

yrs.

mos.

da.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent Inf. Asy.*(Address) *1401 Division St.*

## 15-

JAN 3 - 1915

Filed

191

HARRY O. ANDERSON,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *December 31st, 1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec. 10th, 1914, to Dec. 31st, 1914*that I saw him die on *Dec 31st, 1914*and that death occurred, on the date stated above, at *10:45 a.m.*

The CAUSE OF DEATH\* was as follows:

*Malnutrition and**Malassimilation*

(Duration) yrs. mos. da.

CONTRIBUTORY *Intestinal Intoxication*

(Secondary)

(Duration) yrs. mos. da.

(Signed) *Charles J. Donnan* M. D.*Dec. 29, 1914. (Address) 5 E. Read St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted if not at place of death?

Former or usual residence *St. Vincent Inf. Asylum*19-PLACE OF BURIAL OR REMOVAL, *Cathedral*DATE OF BURIAL, *Jan. 3, 1915*20-UNDERTAKER, *Martin F. Hayes*ADDRESS, *467 Lafayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4 N. Lakewood* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Wilhelmina D. Paine*(Residence in Baltimore: No. *4 N. Lakewood* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *May 5, 1870*

(Month)

(Day)

(Year)

7-AGE, *44* yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Nurse Note*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *August Oble*11-BIRTHPLACE OF FATHER (State or Country), *German*12-MAIDEN NAME OF MOTHER *Wilhelmina Pipe*13-BIRTHPLACE OF MOTHER (State or Country), *German*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Ridd*(Address) *4 N. Lakewood Ave.*

15-JAN 4 - 1915

ROBERT KRAUTER,

Filed..... 191... Serial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Jan 4, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 27, 1914*, to *Jan 4, 1915*, that I saw her alive on *Jan 1, 1915*, and that death occurred, on the date stated above, at *12* m. The CAUSE OF DEATH\* was as follows:*Chronic Bronchitis & Low Spirits*  
(Duration) *10* yrs. *10* mos. *10* ds.CONTRIBUTORY (Secondary) *Weakness*(Duration) *10* yrs. *10* mos. *10* ds.(Signed) *Geo. W. Paine* M. D.*Jan 4, 1915* (Address) *4 N. Lakewood Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *Jan 5, 1915*20-UNDERTAKER *Wendell Lippert & Son*ADDRESS *32 S. Maryland*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81589

## CERTIFICATE OF DEATH.

C81589

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3314 Elgin Av.*, St. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Rosalie Hart*(Residence in Baltimore: No. *3314 Elgin Av.* St. *15* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*white*5-SINGLE,  
MARRIED, *single*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Unknown*, *1837*  
(Month) (Day) (Year)

## 7-AGE,

*about 78*

If LESS than 1 day,

...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),*Balto. Md.*

## 10-NAME OF FATHER,

*Charles J. Hart*11-BIRTHPLACE OF FATHER  
(State or Country),*England*

## 12-MAIDEN NAME OF MOTHER

*Margaret Gray Talpenny*13-BIRTHPLACE OF MOTHER  
(State or Country),*England*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Reba Hart*(Address) *3314 Elgin Av.*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan*, *2*, *1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Aug 9 1914*, to *Jan 2 1915*,  
that I saw her alive on *Jan 1 1915*,  
and that death occurred, on the date stated above, at *11<sup>15</sup> am.*

The CAUSE OF DEATH\* was as follows:

*General Apoplexy*(Duration) *4* yrs. *4* mos. *30* ds.CONTRIBUTORY  
(Secondary)(Duration) *4* yrs. *4* mos. *30* ds.(Signed) *Robert H. Kuehn* M. D.191... (Address) *1001 W. Lenoir St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*London Park* *Jan 4, 1915*

## 20-UNDERTAKER,

## ADDRESS

*E. M. Mitchell* *1201 W. Fayette St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18-

Filed

JAN 4 - 1915

ROBERT H. KRAUTER,

Burial Permit Clerk

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81590

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

9 C81590

REGISTERED NO. C

### 1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 9 Durham St. 7 WARD)

### 2-FULL NAME

(Residence in Baltimore: No. 946 9 Durham St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH July 26 1912 (Month) (Day) (Year)

7-AGE 2 yrs. 5 mos. 7 ds. or min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Balto City

10-NAME OF FATHER John F. Belasky

11-BIRTHPLACE OF FATHER (State or country) New York

12-MAIDEN NAME OF MOTHER Mary A. Pletka

13-BIRTHPLACE OF MOTHER (State or country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Belasky (Address) 946 9 Durham St

JAN 4 - 1915 ROBERT KRAUTER, Registrar

Filed 1915 Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January 3rd 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1915, to Jan 3rd 1915, that I saw her alive on Jan 3rd 1915, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Diphtheritic Croup

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Chas B. Fisher M.D. 1915 [Address] 830 N Broadway

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holy Redeemer Jan 4 1915

UNDERTAKER ADDRESS

William Cook 602 E. North

230 P. M.



C81591

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

28 C81591

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1319 Eusev*

ST.:

WARD) *9*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Martin J. McHale*Residence in Baltimore: No. *1319 Eusev*St.: *4* yrs. *0* mos. *0* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Married*

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

*In line 8*

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Foreman in Balt. city water dept.*

9-BIRTHPLACE,

(State or Country),

*Balt. Md.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Della McHale*(Address) *1319 Eusev*

15-

JAN 4 - 1915

Filed *ROBERT KRAUTER, Registrar*

## MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH

*Dec 31**1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 1, 1914, to Dec 31, 1915.*that I saw him alive on *Dec 30, 1915.*and that death occurred on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Pulmonary Tuberculosis*(Duration) *2* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

*Tuberculosis*(Duration) *1* yrs. *0* mos. *0* ds.(Signed) *Harvey S. Keen, M.D.**Jan 1, 1915.* (Address) *20 E. Preston St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*New Cathedral Cemetery*

DATE OF BURIAL,

*Dec 4, 1915.*

20-UNDERTAKER

*Henry Wood*

ADDRESS

*1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81592

## CERTIFICATE OF DEATH

C81592

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 10 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 47 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

1-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed),

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JAN 4 - 1915

ROBERT KRAUTER,  
Burial Permit Clerk  
REGISTRAR

New Cathedral Cemetery  
Henry Hock Son

Jan 5, 1915  
1301 E. Bay St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C81593

PLACE OF DEATH

CITY OF BALTIMORE (No. 1016 Bennett Place St. 18 WARD)

FULL NAME

Andrew J. Dennis

(Residence in Baltimore: No. 1016 Bennett Place

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 18 yrs. 8 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED OR DIVORCED

Married  
(Write the word)

DATE OF BIRTH

June 22, 1881  
(Month) (Day) (Year)

AGE

83 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Retired Window  
(b) General nature of industry, business, or establishment in which employed (or employer) Shade Maker

BIRTHPLACE  
(State or country)

Baltimore Md

NAME OF FATHER

Wm. Dennis

BIRTHPLACE OF FATHER  
(State or country)

Cecil Co. Md

MAIDEN NAME OF MOTHER

Marie Schillerberg

BIRTHPLACE OF MOTHER  
(State or country)

Baltimore Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

W. H. Dennis  
(Informant)

(Address) 1016 Bennett Place

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 3, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

May 4, 1914, to Jan 3, 1915.

that I saw him alive on Jan 3, 1915.

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

Vascular Heart Disease

(Duration) 15 yrs. 8 mos. 11 ds.

Contributory (SECONDARY)

Family

(Duration) 6 yrs. 6 mos. 11 ds.

(Signed)

Thomas Nelson M. D.  
Jan 4, 1915 (Address) 1103 1/2 Fulton Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 83 yrs. 8 mos. 11 ds. In the State 83 yrs. 8 mos. 11 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

Western

DATE OF BURIAL

Jan 5, 1915

UNDERTAKER

Geo W Little

ADDRESS

531 1/2 Fremont Ave

JAN 4 - 1915

Filed

ROBERT KRAUTER  
Burial Permit Clerk  
REGISTRAR



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81594

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.: - yrs. - mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, .... hrs. or .... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17. I HEREBY CERTIFY. That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at 6.4 m. The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JAN 4 - 1915

Filed ....., 191

ROBERT . KRAUTER,

Burial Permit Clerk,

REGISTRAR

London Park

Robt. S. Little

Jan 4, 1915

531 W. Belmont

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *524 N Pulaski* ST.: *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Caleb Fowler Gimson*(Residence in Baltimore: No. *524 N Pulaski* St.: ..... yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*6-DATE OF BIRTH, *August 4th*, 1913

(Month)

(Day)

(Year)

7-AGE, *1* yrs. *4* mos. *29* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), *Mechanicburg Pa*

## PARENTS.

10-NAME OF FATHER, *Walter F. Gimson*11-BIRTHPLACE OF FATHER (State or Country), *Phila. Pa*12-MAIDEN NAME OF MOTHER *Bulah Still*13-BIRTHPLACE OF MOTHER (State or Country), *Pine Grove Pa.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Krauter*(Address) *701 N. Carroll Ave.*

15-

JAN 4 - 1915

ROBERT KRAUTER,

Filed..... 191... *SOULI. Peralt. Clerk.* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 3rd*, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *January 1st* 1915, to *January 3rd* 1915, that I saw him alive on *January 3rd* 1915, and that death occurred, on the date stated above, at *8:45* m.

The CAUSE OF DEATH\* was as follows:

*Gastro-Intestinal*(Duration) ..... yrs. .... mos. .... ds. *5*CONTRIBUTORY (Secondary) *Biliary Excess*(Duration) ..... yrs. .... mos. .... ds. *2*(Signed) *J. H. Gimson* M. D.*Jan 3rd*, 1915 (Address) *701 N. Carroll Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Western Cemetery*DATE OF BURIAL, *Jan. 5th*, 191520-UNDERTAKER *Geo. L. Schwalbe & Co.*ADDRESS *2401 Thad Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2032 E. North Ave* ST.; *8* WARD)2. FULL NAME *Henrietta Ripke*(Residence in Baltimore: No. *2032 E. North Ave* St. *61* yrs., mos. ds.)REGISTERED No. C *50*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3. SEX, *Female*4. COLOR OR RACE, *White*5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6. DATE OF BIRTH, *Dec 26<sup>th</sup>, 1852*

(Month)

(Day)

(Year)

7. AGE, *62* yrs., *7* mos., *7* ds.

If LESS than 1 day, .... hrs. or .... min.

## 8. OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE, (State or Country), *Germany*10. NAME OF FATHER, *Henry Krumm*11. BIRTHPLACE OF FATHER, (State or Country), *Germany*12. MAIDEN NAME OF MOTHER, *Annie K. Riessman*13. BIRTHPLACE OF MOTHER, (State or Country), *Germany*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Barrie Schuler*(Address) *2032 E. North Ave*

JAN 4 - 1915

ROBERT . KRAUTER,

Filed *191* Marial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH, *Jan 2*

(Month)

(Day)

(Year) *1915*17. I HEREBY CERTIFY. That I attended deceased from *June 2* 191*4*, to *Jan 2* 191*5*,that I saw her alive on *Jan 2* 191*5*, and that death occurred, on the date stated above, at *3<sup>rd</sup>*, m.

The CAUSE OF DEATH\* was as follows:

*Diabetes*(Duration) *7* yrs., *7* mos., *7* ds.

## CONTRIBUTORY (Secondary)

(Duration) *7* yrs., *7* mos., *7* ds.(Signed) *August Horn* M. D.191*4* (Address) *4062 St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL, *Baltimore Gen.*DATE OF BURIAL, *Jan 5* 191*5*20. UNDERTAKER, *H. Sander Sons*ADDRESS, *1710 Fleet St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81597

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No)

2-FULL NAME

(Residence in Baltimore: No)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

About 58

If LESS than 1 day, hrs., or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (for employer)

Seaman

9-BIRTHPLACE  
(State or country)

Norway

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER  
(State or country)

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER  
(State or country)

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)  
My statement on admission to Hospital.

15-

JAN 4 - 1915

ROBERT KRAUTER,  
Burial Permit Clerk  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

January 3, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on January 2, 1915, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Embolism of Coronal Artery - 1

(Probably from vegetation of mitral Artery)

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

H. R. Carter

Jan 3, 1915

[Address]

H. R. Carter, M.D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Trinity Cemetery

DATE OF BURIAL

Jan 4, 1915

ADDRESS

17 S. Bayway

20-UNDERTAKER

H. C. Hughes

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81598

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81598

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *408 Lewis*)ST. *5* WARD)2-FULL NAME *George McLaughlin*

(If death occurred in a hospital or institution, give its NAME instead of street and number and file No. 18.)

Residence in Baltimore: No. *408 Lewis*St. *37* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Black* 5-SINGLE *Married*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)6-DATE OF BIRTH *Not Known* 18 *78*  
(Month) (Day) (Year)7-AGE *37* yrs. mos. ds. or min.?  
If LESS than 1 day, hrs.8-OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
*Driver*9-BIRTHPLACE  
(State or country) *Md.*PARENTS  
10-NAME OF FATHER *David McLaughlin*  
11-BIRTHPLACE OF FATHER (State or country) *Not Known*  
12-MAIDEN NAME OF MOTHER *Not Known*  
13-BIRTHPLACE OF MOTHER (State or country) *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lottie McLaughlin*  
(Address) *408 Lewis*

JAN 4 - 1915

ROBERT K. KRAUTER  
Burial Permit Clerk  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 1st* 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec. 1st* 1914, to, *Jan 1st* 1915, that I saw him alive on *Jan 1st* 1915, and that death occurred, on the date stated above, at *5:35 P.M.*

The CAUSE OF DEATH\* was as follows:

*Empyema*(Duration) yrs. mos. ds. *7*  
Contributory (SECONDARY) *Pleurisy*  
(Duration) yrs. mos. ds. *1*  
(Signed) *Jacob L. Winner* M.D.  
*1-1-1915* [Address] *308 B'way*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Asbury**Jan 4* 1915

20-UNDERTAKER

ADDRESS

*John W. Henderson* *31 N. Caroline*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81599

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81599

PLACE OF DEATH

## CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. *20 Lafayette Ave. & John*

REGISTERED NO. C

FULL NAME

*Sadie E. Anderson*ST. *15* WARD(Residence in Baltimore: No. *4004 Ridgwood Ave.*St. *15* yrs. *3* mos. *15* ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*female*

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

*July 15*

(Month)

(Day)

*1887*  
(Year)

7-AGE,

*27*yrs. *6* mos. *17* ds.

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

9-BIRTHPLACE, (State or Country),

*North Adams, Mass.*

10-NAME OF FATHER,

*Frank H. Soule*

11-BIRTHPLACE OF FATHER (State or Country),

*Mass.*

12-MAIDEN NAME OF MOTHER

*Mary T. Gadbois*

13-BIRTHPLACE OF MOTHER (State or Country),

*Mass.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *G. Norman Anderson*(Address) *4004 Ridgwood Ave.*

15-

JAN 4 - 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January*

(Month)

*3*

(Day)

*1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 2* 1915, to *Jan 3* 1915,that I saw her alive on *Jan 3* 1915,and that death occurred, on the date stated above, at *10.40 A.* m.

The CAUSE OF DEATH\* was as follows:

*Acute Dilatation of Heart*(Duration) *10* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

*Myocardial Stenosis*(Duration) *10* yrs. *1* mos. *1* ds.(Signed) *W. H. Morris**Jan 3, 1915* (Address) *Wanam's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

*2*

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*4004 Ridgwood Ave.*

19-PLACE OF BURIAL OR REMOVAL,

*Fitchburg, Mass.*

20-UNDERTAKER

*John C. Hughes Co.*

DATE OF BURIAL,

*Jan 6, 1915*ADDRESS *1432**Bennett*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sp. 5-19-13-M. & T.-500 Bks.

C81600

HEALTH DEPARTMENT—CITY OF BALTIMORE C81600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 E. North Ave.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Propf.

(Residence in Baltimore: No. 2303 E. North Ave.

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. Feb. 15th, 1875 (Month) (Day) (Year)

7-AGE. 39 yrs. 10 mos. 16 da. If LESS than 1 day, ....hrs. or ....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Cigar Maker (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Henry Propf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Lena Kreiger

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Propf

(Address) 2303 E. North Ave.

15- JAN 4 - 1915, ROBERT KRAUTER, Filed, 191, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 1/15., 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20/14 191, to Jan. 1/15. 191, that I saw him alive on Dec. 31/14. 191, and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation of Heart.

(Duration) 5 yrs. 3 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

Jan. 3/14 191 (Address) 933 Hanover St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

London Park Cem Jan 4, 1916

20-UNDERTAKER ADDRESS 1039

E. Schlamander Hanover

C81601

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81601

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

2-FULL NAME

(Residence in Baltimore: No

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-MARRIED

WIDOWED

ON-DECEASED

(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day, hrs.,

ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

PARENTS

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

15-

ROBERT J. KRAUTER,

Mural Permit Clerk,

REGISTRAR

JAN 4 - 1915

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

November 20, 1913, to January 3, 1915,

that I saw him alive on January 3, 1915,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

Bright's disease, chronic  
interstitial nephritis

(Duration) 1 yrs 1 mos 15 ds.

Contributory  
(SECONDARY)

(Duration) 24 hrs.

(Signed), Chas. W. Wogel, M. D.

January 4, 1915, (Address) U. S. Marine Hospital

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs 1 mos 14 ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Int. bur. in cemetery Jan 6, 1915

20-UNDERTAKER

ADDRESS

R. E. Gross 405 Moskenny St

Every item of information should be carefully supplied. Age should be stated exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81602

## CERTIFICATE OF DEATH.

154 C81602  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 Chestnut Ave. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 3600 Chestnut Ave. St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 4 - 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

## 17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

(Signed) R. J. Krauter M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81603

HEALTH DEPARTMENT-CITY OF BALTIMORE

C81603

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 307 N. Pulaski

ST. 20 WARD)

2-FULL NAME Mrs. Mary E. Smith

(Residence in Baltimore: No. 307 N. Pulaski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH June 22, 1846 (Month) (Day) (Year)

7-AGE 68 yrs. 6 mos. ds. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE (State or country) Balto. Md.

10-NAME OF FATHER Benjamin Tucker

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Mc Kenna

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Katharine Carroll

(Address) 120 N. Biddle St

JAN 4 - 1915

ROBERT . KRAUTER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January 15, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from Nov. 9, 1914, to Jan. 15, 1915, that I saw her alive on Jan. 15, 1915, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows: Intracranial tumor

Duration 1 yrs. mos. ds.

Contributory (SECONDARY) Paralysis (Duration) 3 yrs. mos. ds.

(Signed) Benjamin B. Adams M. D. Jan 20, 1915 (Address) 252 N. Gay St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Olivet Cem DATE OF BURIAL Jan 4, 1915

20-UNDERTAKER John J. Sawyer & Son ADDRESS 1318 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C<sub>0</sub>

30 C81604

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

834 E. Preston

ST.

9 WARD)

Marie Rosalie Ward

834 E. Preston

St.: 1 yrs. 4 mos. 26 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec. 6, 1913  
(Month) (Day) (Year)

7 AGE

1 yrs. 4 mos. 26 ds. or min.?

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Hotel

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

John S. Ward

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Marie Sander Meyer

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John S. Ward

(Address)

834 E. Preston

15 JAN 4 - 1915

Filed

ROBERT KRAUTH

Burial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 2, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Dec 16, 1914, to, Jan 2, 1915.

that I saw her alive on Jan 2, 1915, and that death occurred, on the date stated above, at 4:40 p.m.

The CAUSE OF DEATH\* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 22 ds.

Contributory (SECONDARY)

Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) Gustav H. Woltersch, M. D.

Jan 2, 1915 (Address) 1210 Guilford Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Jan 5, 1915

20 UNDERTAKER

M. L. Lutz

ADDRESS

1915

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81605

## CERTIFICATE OF DEATH.

C81605.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2042 Fairmount Ave.* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 15.)

## 2-FULL NAME

(Residence in Baltimore: No. *2042 Fairmount Ave.* St.; *6* yrs., *3* mos. *1* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX,

*Male*

## 4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH,

*September*, 18*36*  
(Month) (Day) (Year)

## 7-AGE,

*58* yrs., *3* mos., *1* da.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

*Superintendent*

## 9-BIRTHPLACE, (State or Country),

*Maryland*

## PARENTS.

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

*James Bonday**England**Katherine Brumman**Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mrs. Susan Bonday*(Address), *2042 Fairmount Ave.*

## 15-

Filed

JAN 4 - 1915

191

ROBERT BRAUTER,  
Chief Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 1*, 191*5*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Oct 2* 191*4* to *Jan 1* 191*5*,  
that I saw him alive on *Dec 31* 191*4*,  
and that death occurred, on the date stated above, at *10:15 a.m.*

The CAUSE OF DEATH\* was as follows: -

*Multiple Myeloma*  
*Chronic*  
(Duration) *3* yrs., *3* mos., *1* da.

## CONTRIBUTORY (Secondary)

(Duration) *3* yrs., *3* mos., *1* da.(Signed) *J. S. Gilroy* M. D.*Jan 3*, 191*5* (Address) *622 W. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs., *3* mos., *1* da. In the State *6* yrs., *3* mos., *1* da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Int. Annet cemetery*

## DATE OF BURIAL,

*Jan. 4*, 191*5*

## 20-UNDERTAKER

*W. J. Henley*

## ADDRESS

*2012 E. Madison*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



HEALTH DEPARTMENT—CITY OF BALTIMORE

### CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 604 S. W. 11th St. St.; 1 yrs., 1 mos., 1 ds.)

**MEDICAL CERTIFICATE OF DEATH.**

5-SINGLE,  
MARRIED, *Wid*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

..... April ..... 1895  
(Month) (Day) (Year)

...hrs. or...min.?

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

10-NAME OF FATHER.

**TS.** **11-BIRTHPLACE**  
**OF FATHER**  
(State or Country)

**12-MAIDEN NAME  
OF MOTHER**

**13-BIRTHPLACE  
OF MOTHER**  
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Baker  
(Address) 1915 Baker St.

15-

JAN 4 - 1915 ROBERT . KRAUTER  
Filed..... 191... Serial Permit Clerk

.....  
..... Jan ..... 5, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
March 1 1914, to Jan 3 1915  
that I saw her alive on Jan 2 1916  
and that death occurred, on the date stated above, at m

The CAUSE OF DEATH\* was as follows:

Canine of Fox

(Duration) 1 yrs. mo. da

CONTRIBUTORY.....  
(Secondary).....  
..... (Duration)..... yrs..... mos..... da

(Signed).....*J. Thomas Nelson*.....M. D.  
.....*Jan 3, 1915*.....(Address).....*1123 N. Fulton Ave.*.....

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... da. In the State ..... yrs. .... mos. .... da.

Where was disease contracted,  
if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

Wm. C. ... 1915

[illegible]

W. C. Cullen Esq. Nov 21/9

for a Nelson Giltner

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81607

## CERTIFICATE OF DEATH

64 C81607  
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 4 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 45 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 MARRIED married (Write the word)

6 DATE OF BIRTH June 21, 1838 (Month) (Day) (Year)

7 AGE 76 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION Barber (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Germany (State or country)

10 NAME OF FATHER John Schlesinger

11 BIRTHPLACE OF FATHER Germany (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER Germany (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Fredericka Schlesinger

(Address) 308 Park Ave

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 January, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1914, to Jan. 3, 1915, that I saw him alive on Jan. 3, 1915, and that death occurred, on the date stated above, at 3 p. m. The CAUSE OF DEATH\* was as follows:

Cerebral haemorrhage  
arteriosclerosis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Dr. Robert K. Kasper M. D. Jan. 4, 1915. (Address) 1325 Park Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Paul's Lutheran Cemetery Jan 5, 1915

20 UNDERTAKER ADDRESS

Mrs A Rhodes 730 Palmer

JAN 4 - 1915

Filed 191

ROBERT K. KASPER, M.D.  
Burial Permit Officer  
REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81608

66 C81608

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *624 S. Belnord Ave* ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *624 S. Belnord Ave* St. *70* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*  
(Write the word.)6-DATE OF BIRTH, *February*, 18*44*  
(Month) (Day) (Year)7-AGE, *71* yrs., mos. ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *House Wife*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country) *Germany*10-NAME OF FATHER, *George Grubbs*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. George B. Hill*(Address) *312 Richard St.*

15-JAN 4 - 1915

Filed 1915

HARRY O. BILBRO, Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *about Oct 1* 191*1*, to *May 2* 1915, that I saw her alive on *May 2* 1915, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Paralysis*  
*Gradual Paralysis*  
(Duration) *3* yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Geo. B. Hill* M. D.  
*May 2* 1915 (Address) *624 S. Belnord Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Balto. Cemetery* *Jan 5, 1915*

20-UNDERTAKER

ADDRESS

*John J. Cowan & Son* *911 Hollis St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81609

HEALTH DEPARTMENT-CITY OF BALTIMORE

C81609

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Pennsylvania Ave

REGISTERED NO. C

CITY OF BALTIMORE (No.

1523 Pennsylvania Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Franciska Gurnity

Residence in Baltimore: No.

1523 Pennsylvania Ave

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female White

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

married

6-DATE OF BIRTH

Unknown, 1833

7-AGE

81 yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

Germany

10-NAME OF FATHER

Charles Duke

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Hild

(Address) 1523 Penna Ave

15-JAN 4 - 1915

JOHN O. ANDREWS,

Filed

Serial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 25, 1915

17-

I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1914, to Dec 28, 1914

that I saw her alive on Dec 28, 1914.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis and general debility

Several months

Contributory (SECONDARY)

advanced years

(Signed)

E. F. Nicholas M. D.

115 W Franklin

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Jan 5, 1915

20-UNDERTAKER

Martin Fuchs 606 Lafayette

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81610

## CERTIFICATE OF DEATH.

154 C81610  
REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 N. Baltimore ST.; 19 WARD)

## 2-FULL NAME

Madara C. Starr

(Residence in Baltimore: No. 1518 N. Baltimore St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., 3 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

## 6-DATE OF BIRTH,

Unknown 1845  
(Month) (Day) (Year)

## 7-AGE,

69 yrs. mos. ds.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE, (State or Country),

Maryland

## 10-NAME OF FATHER,

Orelly Pawkins

## 11-BIRTHPLACE OF FATHER (State or Country),

Maryland

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. J. C. Scott

(Address)

1518 N. Baltimore St.

## 15-

JAN 4 - 1915

Filed

191

HARRY O. ANDREWS

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month) (Day) (Year)

Jan 2, 1915

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 1914 to Jan 2 1915, that I saw her alive on Jan 2 1915, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

Malnutrition old age

(Duration) 1 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed)

Emily Hoop

M. D.

Jan 3, 1915 (Address) 729 E. Lexington Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Westmoreland

Jan 5, 1915

## 20-UNDERTAKER

## ADDRESS

John J. Lawan &amp; Son 210 Hollister

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81611

## CERTIFICATE OF DEATH.

120 C81611  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Modena ST. 6 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 18 N. Modena St. 24 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

(Write the word.) Married

## 6-DATE OF BIRTH

Not known, 1 (Month) (Day) (Year)

## 7-AGE

68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

Bohemia

## 10-NAME OF FATHER,

John Ales

## 11-BIRTHPLACE OF FATHER, (State or Country),

Bohemia

## 12-MAIDEN NAME OF MOTHER

Not known

## 13-BIRTHPLACE OF MOTHER, (State or Country),

Not known

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank Ales  
18 N. Modena St.

## 15-

JAN 4 - 1915

Filed 1915

HARRY O. ANDREWS

Baptist Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 2, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 26 1914 to Jan 2 1915, that I saw him alive on Jan 2 1915, and that death occurred, on the date stated above, at 2:30 p.m.

The 'CAUSE OF DEATH' was as follows:

Heart Disease &amp; kidney trouble (Bright)

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Ales M. D.

1915 (Address) 16 S. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

Undertaker

Frank Grackley

## DATE OF BURIAL,

Jan 5, 1915

## ADDRESS

1904 1/2 Ballard Ct

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81612.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

79 C81612  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1224 E Madison

ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Rio Janiero Hudgins

(Residence in Baltimore: No. 1224 E Madison

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Widow

## 6-DATE OF BIRTH,

Columbus, 1837  
(Month) (Day) (Year)

## 7-AGE,

78 yrs. mos. ds.

## IF LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)  
None

## 9-BIRTHPLACE,

(State or Country), Md

## PARENTS.

## 10-NAME OF FATHER,

Ezekiel Cannon

## 11-BIRTHPLACE OF FATHER,

(State or Country), Md

## 12-MAIDEN NAME OF MOTHER

Susan MacNamar

## 13-BIRTHPLACE OF MOTHER

(State or Country), Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. E. Smith

(Address)

1107 N. Belmont

## 15-

JAN 4 - 1915

HARRY O. ANDERSON

Filed

191

Burial Permit Officer

Registrar

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 2<sup>nd</sup>, 1915  
(Month) (Day) (Year)

## 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Elyah L. Russell M. D.

(Coroner)

Jan 2<sup>nd</sup>, 1915 (Address) 423 N. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

## Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Baltimore Cemetery

Jan 5<sup>th</sup>, 1915

## 20-UNDERTAKER

## ADDRESS

Walter E. Haller

221 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81613

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81613

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *Benedict, Md.* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

## 4-COLOR OR RACE

## 5-SINGLE, MARRIED, WIDOWED, DIVORCED

*Female white married*

## 6-DATE OF BIRTH

*Don't know*  
(Month) (Day) (Year)

## 7-AGE

*60*

IF LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Housework*

## 9-BIRTHPLACE, (State or Country)

*Md.*

## 10-NAME OF FATHER

*Richard Farrell*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Md*

## 12-MAIDEN NAME OF MOTHER

*Don't know*

## 13-BIRTHPLACE OF MOTHER (State or Country)

*Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Wm A Higge*

(Address)

*Benedict Md*

## 15-

JAN 4 - 1915

HARRY O. ANDREWS

Filed....., 191.....

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan. 3, 1915*  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Dec. 8, 1914*, to *Jan 3, 1915*, that I saw her alive on *Jan 3, 1915* and that death occurred, on the date stated above, at *2:00* in.

The CAUSE OF DEATH\* was as follows:

*Cerebro-spiral Disease*

(Duration)

*Don't know*  
yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration)

yrs. mos. ds.

(Signed)

*Edward P. Smith* M. D.

(Address)

*Mercy Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

*Don't know*

Former or usual residence

*Benedict Md*

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Higginville Md**Jan 5, 1915*

## 20-UNDERTAKER

## ADDRESS

*Gerungs & Co**2008 Orleans*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81614

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH *University Md Hosp*  
CITY OF BALTIMORE (No. *4* ST. *4* WARD)  
2-FULL NAME *Margaret Owens*  
(Residence in Baltimore: No. *812 C St. Sparrow Point* St. *7* yrs., *0* mos. *0* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Widow</i> (Write the word.)
6-DATE OF BIRTH, <i>Feb 15, 1847</i> (Month) (Day) (Year)		
7-AGE, <i>67</i> yrs. <i>9</i> mos. <i>18</i> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>England</i>		
PARENTS.	10-NAME OF FATHER, <i>Joseph Watson</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Ireland</i>	
	12-MAIDEN NAME OF MOTHER, <i>Caroline Stewart</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Ireland</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Carrie Parham*  
(Address) *812 C St. Sparrow Pt*

15-  
JAN 4 - 1915  
Filed..... 191...  
Burial Permit Clerk  
Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 3, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*  
(Inquest, autopsy or inquiry.)  
And that said deceased came to *his* death  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration)..... yrs. .... mos. .... ds.  
CONTRIBUTORY (Secondary) *Fractured Skull (accident)*

(Signed) *J. H. Carroll* M. D.  
(Coroner)  
Jan 4, 1915 (Address) *101 C St. Sparrow Pt*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the *60* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *Sparrow Pt*

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem*

DATE OF BURIAL, *Jan 6, 1915*

20-UNDERTAKER, *J. Faw McLeary*

ADDRESS *39 E. Fort St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17* ST.; *17* WARD)2-FULL NAME *Beatrice White*(Residence in Baltimore: No. *508 Biddle Alley* St.; ..... yrs., ..... mos., ..... ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *7 Nov 2*, 1912

(Month)

(Day)

(Year)

7-AGE, *2 yrs. 2 mos. 2 ds.*

If LESS than 1 day, ..... hrs. or ..... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *Child*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto. City, Md*10-NAME OF FATHER, *David White*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER *Mary E. White*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. White*(Address) *913 Pearl St*

15-

JAN 4 - 1915

JERRY O. ALLEN, Registrar.

Filed.....

101.....

Burial Permit Office

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 2*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 30* 1914, to *Jan 2* 1915, that I saw her alive on *Jan 2* 1915, and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Cerebro-spinal Meningitis*  
*(Epidemic)*  
..... (Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary).....

(Duration).....

yrs.

mos.

ds.

(Signed) *Chas. C. Jones*

M. D.

*Jan 2*, 1915. (Address) *Md. Gen. Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....

yrs.

mos.

ds.

In the State.....

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

at *508 Biddle Alley*19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn Cemetery*DATE OF BURIAL, *Jan 3*, 191520-UNDERTAKER *Wm. A. Elliott*ADDRESS *5th. Poyner Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

081616

C81616

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11* ST., *11* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *930 No Cutlar* St.; *—* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*Colored*5-~~SINGLE~~~~MARRIED~~~~WIDOWED~~~~OR DIVORCED~~

(Write the word.)

## 6-DATE OF BIRTH,

*Unknown*, *1872*  
(Month) (Day) (Year)

## 7-AGE,

*43* yrs., *—* mos., *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Minister*9-BIRTHPLACE,  
(State or Country),*Va*

## 10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER  
(State or Country),*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maggie Gray*(Address) *518 E. Calvert St.*

JAN 4 - 1915

BARRY O. ANDREWS

Filed....., 191.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 3rd*, 191*5*.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY That I attended deceased from

*Jan 2* 191*5*, to *Jan 3* 191*5*,that I saw him alive on *Jan 3* 191*5*,and that death occurred, on the date stated above, at *11* a.m.

## The CAUSE OF DEATH\* was as follows:

*Anginal Pectoris*  
*due to pressure from*  
*urinary suppletion*  
*Unknown*  
*Unknown* (Duration) *—* yrs., *—* mos., *—* ds.CONTRIBUTORY  
(Secondary)*Mediac asthma*  
(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *W. J. Wolf* M. D.*Jan 3*, 191*5*. (Address) *1137 Franklin St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the *—* yrs., *—* mos., *—* ds. State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *930 No Cutlar St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Auburn Cemetery*

## DATE OF BURIAL,

*Jan 6*, 191*5*.

## 20-UNDERTAKER

*Robert J. Elliott* ADDRESS *St. Rogers Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81617

C81617

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1222 William* ST.; *24* WARD)

REGISTERED NO. C

## 2-FULL NAME

*Anna. S. Lindung.*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1222 William* St.; - yrs., - mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Widow*

## 6-DATE OF BIRTH,

*December 14, 1851*  
(Month) (Day) (Year)

## 7-AGE,

*63* yrs. *0* mos. *19* ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*House Work*  
*at home.*

## 9-BIRTHPLACE, (State or Country),

*Germany.*

## 10-NAME OF FATHER,

*C. Valentine Mattes*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany.*

## 12-MAIDEN NAME OF MOTHER

*Mary Leiser*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Germany.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gertrude Brummer.*(Address) *1222 William St.*

## 15-

JAN 4 - 1915

BARRY O. ANDREWS

Filed..... 191..... 2..... 10.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January, 22, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 20, 1914*, to *Jan 2, 1915*, that I saw her alive on *Jan 2, 1915*, and that death occurred, on the date stated above, at *5 P* m. The CAUSE OF DEATH\* was as follows:*Cyctic Worder*  
*Acute Bronchitis*(Duration)..... yrs. *10* mos. .... ds.

## CONTRIBUTORY (Secondary)

*Pulmonary edema*

(Duration)..... yrs. .... mos. .... ds.

(Signed) *Joe A. O'Brien* M. D.*Jan 4, 1915* (Address) *107 E. West St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Holy Cross (A.C.C.)* *1-5, 1915.*

## 20-UNDERTAKER

## ADDRESS

*E. B. Harle**115 E. West St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81618 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH.  
1-PLACE OF DEATH Maryland General Hospital,  
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 11 WARD)  
2-FULL NAME William F. Myers,  
(Residence in Baltimore: No. Non-resident, St.; yrs., mos. ds.)  
REGISTERED NO. C81618  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Unknown, (Write the word.)  
6-DATE OF BIRTH, Could not ascertain, 1, (Month) (Day) (Year)  
7-AGE, 35? yrs. ? mos. ? ds. If LESS than 1 day, ....hrs. or ....min.?  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Farm hand.  
(b) General nature of industry, business, or establishment in which employed (or employer).  
9-BIRTHPLACE, (State or Country), Maryland,  
10-NAME OF FATHER, Henry Miles,  
11-BIRTHPLACE OF FATHER (State or Country), Maryland,  
12-MAIDEN NAME OF MOTHER, Unknown,  
13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Dorsey,  
(Address) Sykesville. Md.

15- JAN 4 - 1915

HARRY O. ANDREWS,  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2nd, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

Accidental burn of the 3d degree,  
(clothes caught fire from stove whilst under the influence of alcohol) Acute cardiac dilatation  
CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.  
(Signed) Frederick Hempel, M. D.  
(Coroner.)  
Jan. 4th, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place In the  
of death .... yrs. .... mos. 7 ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....  
Carroll's Manor, Howard County, Md.  
Former or usual residence ditto.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,  
West Liberty Howard Co. Jan 5, 1915  
20-UNDERTAKER, ADDRESS  
S. Hellmenger & Son, Ellicott City

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81619

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81619

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2917* *2d* *St.*)

ST.; WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *2917* *2d* *St.*)St.: *2* yrs., *7* mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*male*

## 4-COLOR OR RACE,

*white*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Single*

## 6-DATE OF BIRTH,

*June*

(Month)

*2*, *1915*

(Day)

(Year)

## 7-AGE,

*2* yrs., *7* mos., *7* ds.

(Month)

IF LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

*none*

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

*Baltimore*

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER,

(State or Country),

## 12-MAIDEN NAME OF MOTHER,

## 13-BIRTHPLACE OF MOTHER,

(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jacob Imudziejewski*(Address) *2917 2d St.*

## 15-

FILED

JAN 4 - 1915

191

Serial Record Office

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*

(Month)

*4*

(Day)

*1915*

(Year)

I HEREBY CERTIFY, That I attended deceased from *January 3<sup>d</sup>* *1915*, to *January 4<sup>th</sup>* *1915*, that I saw him alive on *Jan 4* *1915*, and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria*

(Duration)

yrs.

*Ca. 3*

ds.

## CONTRIBUTORY (Secondary)

(Duration)

yrs.

*Ca. 3*

ds.

(Signed) *J. J. Januszewski*(Address) *2431 2d St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Stanislaus Roman**Jan. 5<sup>th</sup>* *1915*

## 20-UNDERTAKER,

## ADDRESS

*Stephen J. Falkowski**1032 1/2 E. Madison Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81620

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81620

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *18* WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *866 Hunn St.* St.: *-* yrs. *-* mos. *-* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

## 6-DATE OF BIRTH

*Nov. 7, 1913*  
(Month) (Day) (Year)

## 7-AGE,

*13* yrs. *18* mos. *28* ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

## 9-BIRTHPLACE,

(State or Country), *Maryland*

## 10-NAME OF FATHER,

*Ed. Wilson*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

## 12-MAIDEN NAME OF MOTHER

*Maggie V. Abbott*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Abbott*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Sad M. Abbott*(Address) *120 Callender St.*

## 15-

JAN 4 - 1915

HARRY O. ANDREWS,

Filed

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*1-7-1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*1-2-15* to *1-4-15*that I saw her alive on *1-4-15*and that death occurred, on the date stated above, at *11 a.* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Meningitis*(Duration) *13* yrs. *18* mos. *28* ds.

## CONTRIBUTORY (Secondary)

(Duration) *13* yrs. *18* mos. *28* ds.(Signed) *Quakerbach P. W.* M. D.*1-4-15*, 1915 (Address) *Univ. Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *13* mos. *28* ds. In the State *13* yrs. *13* mos. *28* ds.Where was disease contracted, if not at place of death? *???*Former or usual residence *866 Hunn St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Olwet*

## DATE OF BURIAL,

*Jan 5, 1915*

## ADDRESS

*1003 W. Balto St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81621

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Lamley St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2203 Lamley St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Married

## 6-DATE OF BIRTH,

Oct. 19, 1868.  
(Month) (Day) (Year)

## 7-AGE,

46 yrs. 3 mos. 14 ds.If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).Elevator Operator9-BIRTHPLACE,  
(State or Country),Baltimore

## 10-NAME OF FATHER,

Joseph Helfer11-BIRTHPLACE OF FATHER  
(State or Country),Balto

## 12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER  
(State or Country),Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

Fannie L. Helfer

(Address):

2203 Lamley St.

## 15-

JAN 4 - 1915

Filed.....

191.....

BARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan, 1915.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

June 13 1914 to Jan 2, 1915,  
that I saw him alive on Jan 2, 1915,and that death occurred, on the date stated above, at 10:15 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

GEO. HELFER M. D.Jan. 4, 1915. (Address) 1937 Gough St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Oakland Cemetery

## DATE OF BURIAL,

Jan 5, 1915

## 20-UNDERTAKER

Wm Cook

## ADDRESS

502 E. North  
an

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81622

## CERTIFICATE OF DEATH.

C81622

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *451 Lorraine Ave* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *451 Lorraine Ave.* St.; *65* yrs., - mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

## 6-DATE OF BIRTH.

*September 4th, 1830*  
(Month) (Day) (Year)

## 7-AGE.

*84 yrs. 4 mos. - ds.* If LESS than 1 day. .... hrs. or .... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE.

(State or Country), *Germany*

## 10-NAME OF FATHER.

*Conrad Bender*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Germany*

## 12-MAIDEN NAME OF MOTHER

*Not known*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Heard A. Allen*(Address) *451 Lorraine Ave.*15- *JAN 4 - 1915*

Filed..... 191

Serial Permit Olsr

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 4th, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *September 1913*, to *Jan 4th 1915*, that I saw her alive on *Jan 3rd 1915*, and that death occurred, on the date stated above, at *8 AM*.

The CAUSE OF DEATH\* was as follows:

*Metrol Regurgitation*

## CONTRIBUTORY (Secondary)

*Articular Rheumatism*  
(Duration) *10* yrs. .... mos. .... ds.(Signed) *Geo. N. Hargatry & M.D.**Jan 4th, 1915* (Address) *2537 Greenmount Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL, OR REMOVAL,

*Baltimore*

## DATE OF BURIAL,

*Jan 7, 1915*

## 20-UNDERTAKER

*Geo W Little*

## ADDRESS

*531 E Fremont Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

C81623

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81623

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Chick Home & Infirmary* ST. *6* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Chick Home & Infirmary* St. *3* yrs. *4* mos. *24* ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
WIDOWED, *widowed*  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*April 24*, *1842*  
(Month) (Day) (Year)

## 7-AGE,

*72* yrs. *8* mos. *11* ds.

If LESS than 1 day,

...hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired*

## 9-BIRTHPLACE,

(State or Country),

*Granville, Mass.*

## 10-NAME OF FATHER,

*Salem P. Rose*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Mass.*

## 12-MAIDEN NAME OF MOTHER

*Mar*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Mass*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. P. Rose*(Address) *Box 194 City*

## 15-

Filed

*JAN 5 - 1915*

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 4*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 3* 1915, to *Jan 4* 1915, that I saw him live on *Jan 4* 1915,and that death occurred, on the date stated above, at *4.30 PM*

The CAUSE OF DEATH\* was as follows:

*Cardiac Failure*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Cerebral Hemorrhage*

(Duration) yrs. mos. ds.

## (Signed)

*D. Davis, M.D.**Jan 4, 1915* (Address) *Chick Home & Inf*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *4* mos. *24* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*Chick Home & Inf*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Lorraine Cemetery**Jan 6*, *1915*

UNDERTAKER

ADDRESS *1422**John E. Hughes**Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81624

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81624

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

2. FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

4. COLOR OR RACE.

5. SINGLE,

MARRIED,

WIDOWED,

OR

DIVORCED.

6. DATE OF BIRTH,

7. AGE,

If LESS than 1 day.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE,  
(State or Country),

10. NAME OF FATHER,

11. BIRTHPLACE OF FATHER  
(State or Country),

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER  
(State or Country),

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15.

JAN 5 - 1915

Filed..... 191

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 7 yrs. 3 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20. UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81625

C81625

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *416 E. North Ave.* ST.; *12* WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mon. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Widower*

## 6-DATE OF BIRTH,

*Mar 5*, 18*34*  
(Month) (Day) (Year)

## 7-AGE,

*80* yrs. *10* mos. ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Farmer*

## 9-BIRTHPLACE,

(State or Country),

*Md.*

## 10-NAME OF FATHER,

*Charles McCausland*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Md.*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Philip E. Parlings*  
*416 E. North Ave.*

## 15-

JAN 5 - 1915

ROBERT . KRAUTER

Filed..... 191.....

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 5*, 191*5*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Nov 24* 191*4*, to *Jan 4* 191*5*

that I saw him alive on

*Jan 4* 191*5*and that death occurred, on the date stated above, at *5:20* A.M.

The CAUSE OF DEATH\* was as follows:

*Edema of Lungs*

(Duration)..... yrs..... mos..... ds.

## CONTRIBUTORY (Secondary)

*Chronic Interstitial Nephritis*

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

*Jan 5*, 191*5* (Address) *846 E. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Home de Grace Md.* *Jan 7*, 191*5*

## 20-UNDERTAKER

## ADDRESS

*Wm. Crook* *508 E. North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

C81626

## CERTIFICATE OF DEATH

92 C81626

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 37 P. Barclay St. 3

WARD)

2-FULL NAME

Rosa Breclerman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 37 P. Barclay

St.; 7 yrs. 10 mos. 11 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

April 1, 1912

7-AGE

7 yrs. 10 mos. 11 ds.

IF LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Dependent

9-BIRTHPLACE  
(State or country)

Baltimore

PARENTS

10-NAME OF FATHER

Ellis

11-BIRTHPLACE OF FATHER  
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Rosa

13-BIRTHPLACE OF MOTHER  
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellis Breclerman

(Address)

37 P. Barclay St.

15

FILED

JAN 5 - 1915

ROBERT J. KRAUTER

Morial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 5, 1915

17- I HEREBY CERTIFY. That I attended deceased from

Dec 26, 1914, to Jan 5, 1915

that I saw him alive on Jan 4, 1915

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH\* was as follows:

Solar Pneumonia

Contributory  
(SECONDARY)

(Duration) yrs. 9 mos. 9 ds.  
Acute dilatation of heart

(Signed)

Henry Lynn, M.D.  
751 S. 1st St., Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Luke's Cemetery

DATE OF BURIAL

Jan 5, 1915

ADDRESS

1107 E. Balto St.

20-UNDERTAKER

J. L. Linn



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81627

## CERTIFICATE OF DEATH.

C81627

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Hollins St. 18

## 2-FULL NAME

Delia Long

(Residence in Baltimore: No. 1019 Hollins St.

REGISTERED NO. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.

St.: Unknown yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH,

Unknown, 1 (Month) (Day) (Year)

## 7-AGE,

40 yrs. mos. da. If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE, (State or Country),

Ireland

## 10-NAME OF FATHER,

Michael Holland

## 11-BIRTHPLACE OF FATHER (State or Country),

Ireland

## 12-MAIDEN NAME OF MOTHER

May Lacey

## 13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Long

(Address) 1019 Hollins St.

JAN 5 - 1915

ROBERT J. KRAUTER

Filed 191 Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 3, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1914, to Jan 3 1915, that I saw him alive on Jan 3 1915, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH\* was as follows:

Endocarditis

(Duration) yrs. mos. da. 17

## CONTRIBUTORY (Secondary) Indirect Arteriosclerosis

(Duration) yrs. mos. da. 4

(Signed) J. A. E. Jones M. D.

Jan 4 1915 (Address) 1522 Hollins

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St Peter

## DATE OF BURIAL,

Jan 5, 1915

## 20-UNDERTAKER

John Herman

## ADDRESS

901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94 C81628

PLACE OF DEATH

CITY OF BALTIMORE (No. 1925 W Lafayette St. 16 WARD)

2-FULL NAME Christopher Columbus Batchelor

(Residence in Baltimore: No. 1925 W Lafayette St. yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Oct 18, 1894 (Month) (Day) (Year)

7-AGE 90 yrs. 2 mos. 14 ds. or less than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Carpenter (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER William Batchelor

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Elizabeth Shon

13-BIRTHPLACE OF MOTHER (State or country) Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chris C Batchelor

(Address) 1925 W Lafayette St

15. JAN 5 - 1915 ROBERT KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 5th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1915, to Jan 5th, 1915, that I saw him alive on Jan 4th, 1915, and that death occurred, on the date stated above, at 120 A. M. The CAUSE OF DEATH\* was as follows:

Atheroma of Lung

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) J. M. D. (Address) 833 N. Fullerton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Bonbridge Md DATE OF BURIAL Jan 8, 1915

20-UNDERTAKER ADDRESS 316 Fremont St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81629

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81629

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.: 16 WARD)

2 FULL NAME

(Residence in Baltimore: No.

St.: 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Elizabeth Myers (Wife)

(Address) 806 N. Carey St. Reg.

JAN 5 - 1915

Filed

ROBERT K. KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

December, 1913 to Jan 3rd 1915.

that I saw him alive on Jan. 2nd 1915.

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

General Arterio Sclerosis

(Duration) 4 yrs. mos. ds

Contributory Uraemia (acute Nephritis)

(SECONDARY) (Duration) yrs. mos. 2 ds.

(Signed) J. Dawson Reeder M. D.

Jan. 3rd 1915 (Address) 639 N. Fulton St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Loudon Park Cem

Jan 6, 1915

20 UNDERTAKER

ADDRESS S. E. Cor

Robt. Brooks Son & Co. Calhoun & Hollins

CL



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White  
Hebrew

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

January

(Day)

1868

(Year)

7-AGE

47

yrs.

mos.

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

House wife

9-BIRTHPLACE

(State or country)

Roumania

10-NAME OF FATHER

Joseph Greenberg

11-BIRTHPLACE OF FATHER

(State or country)

Roumania

12-MAIDEN NAME OF MOTHER

Minnie Greenberg

13-BIRTHPLACE OF MOTHER

(State or country)

Roumania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lewis

(Address)

1419 E. Bay St.

15-

JAN 5 - 1915

ROBERT KRAUTER

MARITAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January

4

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 24, 1914, to Jan. 4, 1915,

that I saw her alive on Jan. 4, 1915,

and that death occurred, on the date stated above, at 8.30 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic valvular heart disease  
and Chronic interstitial Nephritis

(Duration)

2

yrs.

mos.

ds.

Contributory  
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Samuel Silverstein M. D.

Jan. 4

1915

(Address)

1121 E. Baltimore St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Mt. Cemetery

Jan 5, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Bay St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81631

## CERTIFICATE OF DEATH.

28 C81631

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1342 N. Calhoun st.

ST. 15

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Randolph Gordon,

(Residence in Baltimore: No. 1342 N. Calhoun st.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Single,

6-DATE OF BIRTH,

May 9th, 1895.  
(Month) (Day) (Year)

7-AGE,

19 yrs. 8 mos. 25 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Fish huckster.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John Gordon,

11-BIRTHPLACE OF FATHER  
(State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Mary E. Molock,

13-BIRTHPLACE OF MOTHER  
(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Gordon.

(Address) 1342 N. Calhoun st.

JAN 5 - 1915  
Filed

ROBERT KRAUTER,

Burial Permit Clerk.

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 31, 1915.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry.

And that said deceased came to his death on the day stated above.  
(Inquest, au- topsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Pulmonary haemorrhage.

(Duration) 15 minutes.  
yrs. mos. ds.CONTRIBUTORY Pulmonary tuberculosis.  
(Secondary)(Duration) 3 mos. ds.  
(Signed) Frederick Hempel M. D.  
(Coroner.)

Jan. 4th, 1914. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Zion

DATE OF BURIAL,

Jan 5, 1915

ADDRESS

1222 Duane st

20-UNDERTAKER

John H Owens

Every item of information should be carefully supplied. Age must be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81632

C81632

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *528 Pine*)ST.: *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *528 Pine*)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

(Month) (Day) (Year) *1872*

7-AGE,

*43* yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cook*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Ind.*10-NAME OF FATHER, *Louis Pearson*11-BIRTHPLACE OF FATHER (State or Country), *Ind.*12-MAIDEN NAME OF MOTHER *Sarah Pearson*13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fannie Monroe*(Address) *904 Argyle Ave.*

15

JAN 5 - 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Filed..... 191.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan. 3, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 15, 1914*, to *Jan. 3, 1915*,that I saw her alive on *Dec. 31, 1914*,and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*(Duration) *3* yrs. *4* mos. *8* ds.CONTRIBUTORY (Secondary) *Pulmonary Hemorrhage*(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *W. S. Stupel* M. D.*Jan. 4, 1915* (Address) *206 N. Federal*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mount Auburn*DATE OF BURIAL, *Jan. 5, 1915*ADDRESS *1227 Duane St.*20-UNDERTAKER *John W. Owens*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81633

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1.54

81633

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1145 Dexter*)

St. *21*

WARD)

REGISTERED NO. C

2-FULL NAME *Winfred M.C. Keven*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1145 Dexter*)

St.: *Chesapeake* yrs. *1* mos. *1* ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)

6-DATE OF BIRTH, *Unknown*, 1840 (Month) (Day) (Year)

7-AGE, *75* yrs. *0* mos. *0* ds. If LESS than 1 day, *0* hrs. or *0* min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER, *Timothy F. Kevingan*

11-BIRTHPLACE OF FATHER, (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John M.C. Keven*

(Address) *1145 Dexter St.*

JAN 5 - 1915 ROBERT . KRAUTER, Burial Permit Clerk.

Filed *191* Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan.* *3rd*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Senility* (Duration) *0* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(Duration) *0* yrs. *0* mos. *0* ds.

(Signed) *Samuel M. D.* (Coroner.)

*Jan 4th* 1915. (Address) *302 Madison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *in the* of death *0* yrs. *0* mos. *0* ds. State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Cross Cem* DATE OF BURIAL, *Jan 6*, 1915

20-UNDERTAKER, *Win Cook* ADDRESS *302 E. North Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81634

## CERTIFICATE OF DEATH.

40 C81634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED,

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JAN 5 - 1915

Filed..... 191.....

ROBERT . KRAUTER,

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

.....

.....

.....

.....

.....

CONTRIBUTORY.....

.....

(Signed)..... M. D.

1-5....., 1915. (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... In the State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

ADDRESS,

20-UNDERTAKER

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81635

## CERTIFICATE OF DEATH.

92 C81635

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1148 York Rd.* ST.: *9*)

## REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1148 York Rd.* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE, *Widow*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Aug 17, 1868*  
(Month) (Day) (Year)

## 7-AGE,

*57* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Ind*

## 10-NAME OF FATHER,

*William Jackson*11-BIRTHPLACE OF FATHER  
(State or Country),*Hartford Co*

## 12-MAIDEN NAME OF MOTHER

*Rachel Ady*13-BIRTHPLACE OF MOTHER  
(State or Country),*Hartford Co*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Henry S. Dorney*

(Address)

*260 Old York Rd*

## 15-

JAN 5 - 1915

ROBERT E. KRAUTER

Filed....., 191.....

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*1 4, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*1 2, 1914, to 1 4, 1914,*that I saw her alive on *1 3, 1914,*and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia, Lobar*(Duration)..... yrs. mos. ds. *3*CONTRIBUTORY  
(Secondary)(Duration)..... yrs. mos. ds. *3*(Signed) *Chas. E. Gaudine* M. D.*1.1.4.1., 1914 (Address) 445 York Rd. Gowan,*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*London Park*

## DATE OF BURIAL,

*Jan. 6., 1915*

## 20-UNDERTAKER

*William Cook*

## ADDRESS

*5016 North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

81636

## CERTIFICATE OF DEATH.

79 81636

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 715 N. Carrollton ave. ST. 16 WARD)

2-FULL NAME Maryanna S. Perkins,

(Residence in Baltimore: No. 715 N. Carrollton ave. St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed, (Write the word.)

6-DATE OF BIRTH, July 8th, 1841, (Month) (Day) (Year)

7-AGE, 73 yrs. 5 mos. 27 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Rev. Robt. S. Vinton,

11-BIRTHPLACE OF FATHER, (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Julia R. Berry,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Millard L. Perkins,

(Address) 715 N. Carrollton av.,

15 JAN 5 - 1915 ROBERT J. KRAUTER, Registrar.

Filed, 191, Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic endocarditis.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) J. Frederick M. D. (Coroner.)

Jan. 5th., 1915 (Address) 1103 Valley st.,

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. da. State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mount Olivet, Jan. 7, 1915.

20-UNDERTAKER, ADDRESS

Stewart Mourn Co 1840 North Ave

681637

## HEALTH DEPARTMENT—CITY OF BALTIMORE

156 681637

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 938 Pennsylvania ave. ST. 17

2-FULL NAME Hermann A. Marks,

(Residence in Baltimore: No. 938 Pennsylvania ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH, April 30th, 1886. (Month) (Day) (Year)

7-AGE, 28 yrs. 8 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Photographer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Frederick R. Marks,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER, Caroline Drage,

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick R. Marks,

(Address) 938 Pennsylvania ave.

15- JAN 5 - 1915 ROBERT . KRAUTER, Registrar. Filed. Burial Permit

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death (Inquest, au- topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxiation by illuminating gas, (suicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. Frederick Hempel, M. D. (Duration) yrs. mos. ds.

Jan. 5th, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, (if not at place of death?)

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Swartz Lane

Jan 6, 1915

20-UNDERTAKER

ADDRESS 916 Penna ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1051 W. Bane* ST.; *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Holden Tather*(Residence in Baltimore: No. *1051 W. Bane St.* St.; *2* yrs., *6* mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)6-DATE OF BIRTH. *December 24th*, 1910

(Month)

(Day)

(Year)

7-AGE. *4* yrs. — mos. *10* ds.

If LESS than 1 day, .... hrs. or .... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *but can't*  
(b) General nature of industry, business, or establishment in which employed (or employer). *but can't*9-BIRTHPLACE, (State or Country). *Baltimore*10-NAME OF FATHER. *John T. Tather*11-BIRTHPLACE OF FATHER (State or Country). *Baltimore*12-MAIDEN NAME OF MOTHER. *Lama E. Downey*13-BIRTHPLACE OF MOTHER (State or Country). *Baltimore*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Lama E. Tather*(Address) *1051 W. Bane St.*

15-

JAN 5 - 1915

MARK O. ANDREWS,

Filed..... 191... Special Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *January 3rd*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 24th* 1914, to *Jan 3rd* 1915, that I saw him alive on *Jan 3rd* 1915, and that death occurred, on the date stated above, at *11:45 P. M.*

The CAUSE OF DEATH\* was as follows:

*Tuberculosis Meningitis*

(Duration) — yrs. — mos. — ds.

## CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) *William J. Sullivan* M. D.*Jan 4th*, 1915. (Address) *1701 N. Fulton Avenue*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Cross Cem.*DATE OF BURIAL, *Jan 6th*, 191520-UNDERTAKER *John J. Fields*ADDRESS *1200 W. Lombard St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81639

## CERTIFICATE OF DEATH

REGISTERED NO. C

120 C81639

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 40 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH *Jan. 6, 1865*  
(Month) (Day) (Year)

7 AGE *50* yrs. mos. ds. or min. 7 If LESS than 1 day, hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
*Housewife.*

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER *Patrick Walsh*

11 BIRTHPLACE OF FATHER  
(State or country) *Ireland.*

12 MAIDEN NAME OF MOTHER *May McQuerry*

13 BIRTHPLACE OF MOTHER  
(State or country) *Ireland.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George Lawrence*

(Address) *2016 Gitting St.*

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 3, 1915*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 28, 1914* to *Jan 3, 1915*, that I saw him alive on *Jan 3, 1915*, and that death occurred, on the date stated above, at *2:30 p.m.* The CAUSE OF DEATH\* was as follows:

*Acute Rheumatism of Heart*

(Duration) yrs. mos. ds. *2*  
Contributory (SECONDARY) *Bright's Disease*  
(Duration) yrs. mos. ds. *3*

(Signed), *J. McWhite* M. D.  
*Jan 5, 1915* (Address) *2274 William St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*London Park Cemetery* *Jan 5, 1915*

20 UNDERTAKER ADDRESS

*Wm. H. Flynn* *422 Light St.*

JAN 5 - 1915

HARVEY O. ANDREWS

Burial Permit Clerk

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81640

## CERTIFICATE OF DEATH.

C81640

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 N North Av. ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Harrison A. FreemanResidence in Baltimore: No. 1619 N North Av.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH,

Aug. 27, 1881  
(Month) (Day) (Year)

## 7-AGE,

33 yrs. 5 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Dentist

## 9-BIRTHPLACE,

(State or Country),

Virginia

## 10-NAME OF FATHER,

Charles Freeman

## 11-BIRTHPLACE OF FATHER

(State or Country),

Va

## 12-MAIDEN NAME OF MOTHER

Maria W. Pitt

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Va

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Freeman(Address) 3714 Jefferson St.

## 15-

JAN 5 - 1915HARRY O. ANDREWS,Filed..... 191..... Burial Permit Clark

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 31, 1915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 30, 1914, to Jan 31, 1915.that I saw him alive on Jan 31, 1915.and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH\* was as follows:

Cerebral (facial)

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Hypertension 109(Signed) E. A. Smith M. D.Jan 3, 1915 (Address) 1605 N North Av.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL, OR REMOVAL,

London Park Cemetery

## DATE OF BURIAL,

Jan 6, 1915

## 20-UNDERTAKER

Edw. J. Flynn

## ADDRESS

422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81641

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1026 W Saratoga

ST. 18 WARD)

2-FULL NAME William Albert Carroll

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1026 W Saratoga St

St. 35 yrs. 8 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH April 27, 1879 (Month) (Day) (Year)

7 AGE 35 yrs. 8 mos. 7 ds. 11 LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work sheet iron worker (b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Albert B. Carroll

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Laura E. Kraemer

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chester Riland, M.D.

(Address) 2532 Edmondson Ave.

15 JAN 5 - 1915 SOBERT J. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 4, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 4, 1914, to January 3, 1915, that I saw him alive on January 3, 1915, and that death occurred, on the date stated above, at 3:30 a.m. The CAUSE OF DEATH was as follows:

Uremia

(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY) Chronic Parenchymatous Nephritis (Duration) 1 yrs. 10 mos. ds.

(Signed) Chester Riland M. D. Jan 4, 1915 (Address) 2532 Edmondson Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2532 Edmondson Ave.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 7, 1915

20 UNDERTAKER Harry Branning

ADDRESS 517 N. Schroeder St.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

681642

## CERTIFICATE OF DEATH.

186 681642

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1437 Andre St

ST. 24

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Wladyslaw Stefanski

(Residence in Baltimore: No. 1437 Andre St

St 4 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1889 (Month) (Day) (Year)

7-AGE, 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

10-NAME OF FATHER, Frank Stefanski

11-BIRTHPLACE OF FATHER, (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Balbina Cowinski

13-BIRTHPLACE OF MOTHER, (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michalina Lisowski

(Address) 1437 Andre St

15- JAN 5 - 1915

Filed 191

RECEIVED O. ANDREWS

Marial Permit Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 4, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry and that said deceased came to His death

(topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH\* was as follows:

(Accidental)

Fractured Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) By a fall of lumber falling on his head

(Duration) yrs. mos. ds.

(Signed) E. J. Scott M. D. (Coroner)

Jan 5, 1915 (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Jan 7, 1915

20-UNDERTAKER, William G. Gierowski

ADDRESS, 168 Eastern Ave.

C81643

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

707 W. Fayette

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Henry Augustus Schmidt

(Residence in Baltimore: No.

707 W. Fayette St.

St.: 56 yrs., 2 mos., 2 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH,

? ? 1860  
(Month) (Day) (Year)

## 7-AGE,

56

If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Stage carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer)... Theatre9-BIRTHPLACE,  
(State or Country),

Baltimore

## 10-NAME OF FATHER,

Henry Schmidt

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. C. Thompson

(Address)

707 W. Fayette St.

## 15-

JAN 5 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 5<sup>th</sup>, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec. 1<sup>st</sup> 1914, to Jan 5<sup>th</sup> 1915, that I saw him alive on Jan 4<sup>th</sup> 1915, and that death occurred, on the date stated above, at 8:30 a.m.  
The CAUSE OF DEATH\* was as follows:

Acute dilatation of heart

CONTRIBUTORY (Secondary) Chronic valvular disease

(Signed) W. Hoffman M. D.  
Jan 5, 1915 (Address) 2100 W. North Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Baltimore

## DATE OF BURIAL,

## 20-UNDERTAKER

G. F. Walker 753 W. 1st Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81644

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81644

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST.; *9* WARD)

## REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *31 W. G St Sparrows R. Ind* St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*June 16, 1899*  
(Month) (Day) (Year)

## 7-AGE,

*15* yrs. .... mos. .... ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. .... *Schoolgirl*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

## 9-BIRTHPLACE,

(State or Country), *Maryland*

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER

(State or Country), *Germany*

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary H. Krautter*(Address) *31 W. G St Sparrows R. Ind*

15-

JAN 6 - 1915

ROBERT . KRAUTER,

Filed

191. Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 4, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *December 17, 1914*, to *Jan 4, 1915*, that I saw her alive on *Jan 3, 1915*, and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH\* was as follows:

*Typhoid fever*

## CONTRIBUTORY (Secondary)

(Signed) *J. M. Vinton**Jan 4, 1915*(Address) *St Joseph's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. *18* ds. State yrs. .... mos. .... ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *31 W. G St Sparrows R. Ind*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Sacred Heart Cemetery Jan. 6., 1915*

## 20-UNDERTAKER

## ADDRESS

*6 M. Underwood 1610 E. Chase*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81645

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Carrollton Ave ST. 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)  
2-FULL NAME Mary Jane Wrigton  
(Residence in Baltimore: No. 822 Carrollton Ave St. 16 yrs. 70 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)  
6-DATE OF BIRTH January 28, 1836  
(Month) (Day) (Year)  
7-AGE 78 yrs. 11 mos. 0 ds. or min.?

8-OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

PARENTS  
10-NAME OF FATHER John Wrigton  
11-BIRTHPLACE OF FATHER (State or country) Ireland  
12-MAIDEN NAME OF MOTHER Elizabeth Ireland  
13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Wilson Cole  
(Address) Forest Park

JAN 6 - 1915

ROBERT KRAUTER,  
Burial Permit Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 5, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Apr, 1914, to, Jan 5, 1915,  
that I saw her alive on Jan 4, 1915,  
and that death occurred, on the date stated above, at 3a m.  
The CAUSE OF DEATH\* was as follows:

Apoplexy  
(Duration) yrs 10 mos. 0 ds.  
Contributory Senility  
(SECONDARY) (Duration) yrs 0 mos. 0 ds.  
(Signed) H. J. Walton M. D.  
Jan 5, 1915 [Address] 722 W North Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenmount Cemetery Jan 7, 1915

20-UNDERTAKER ADDRESS

E. M. Underwood 1610 E. B. Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81646

C81646

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (NO.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jerome Grimes

Residence in Baltimore: No.

Sykesville Md.

St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

6-DATE OF BIRTH,

January, 1888  
(Month) (Day) (Year)

7-AGE,

27 yrs. mos. ds.

If LESS than 1 day,  
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,  
(State or Country),

Maryland

10-NAME OF FATHER,

Frank Grimes

11-BIRTHPLACE OF FATHER  
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

M. Krum

13-BIRTHPLACE OF MOTHER  
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. Frank Lucas

(Address)

Sykesville Md.

15 JAN 6 - 1915

ROBERT . KRAUTER,

Filed

191

MORTAL PERMIT CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

1-5-1915, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-5-1915 to 1-6-1915, that I saw him alive on 1-6-1915, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever  
(Duration) 1 yrs. 2 mos. 7 ds.CONTRIBUTORY  
(Secondary)(Duration) 1 yrs. 2 mos. 7 ds.  
(Signed) O. L. Krumholz, M. D.  
1-6-1915, 1915. (Address) University Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the 27 yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL,

Sykesville Md.

DATE OF BURIAL,

Jan 6, 1915

ADDRESS

20-UNDERTAKER

Jas R. Weer

Sykesville Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

C81647 HEALTH DEPARTMENT—CITY OF BALTIMORE

28 C81647

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2253 W. Baltimore St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 2253 W. Baltimore St.;

10 yrs., 0 mos. 0 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 JAN 6 - 1915

Filed..... 191.....

ROBERT KRAUTH

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from April 1915, to January 1915, that I saw him live on January 5, 1915, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis Pulmonalis.  
about (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert G. Marr D.

Jan 5, 1915 (Address) 218 W. Madison St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2053 W. Balto St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Hebrew Rosevale Jan 6, 1915

ADDRESS 1107 E

A. Quinson &amp; Co Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 Wellington Ave.

ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Mira Phillips

(Residence in Baltimore: No. 839 Wellington Ave.

St.: 30 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Widow

## 6-DATE OF BIRTH,

Dec. 15, 1834  
(Month) (Day) (Year)

## 7-AGE,

80

21

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Invalid  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

Carroll Co. Md.

## PARENTS.

10-NAME OF  
FATHER,

Amos Shipley

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Carroll Co. Md

12-MAIDEN NAME  
OF MOTHER

Accintha Pool

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Carroll Co. Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Walter Gorsuch

(Address) 839 Wellington Ave.

## 15-

JAN 6 - 1915, ROBERT KRAUTER, Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 5<sup>th</sup>, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
June 4<sup>th</sup> 1912, to Jan 5<sup>th</sup> 1915,  
that I saw her alive on Jan 4<sup>th</sup> 1915,  
and that death occurred, on the date stated above, at G. W. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the  
frontal bone  
(Duration) 5 yrs. mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

## (Signed)

Geo. T. Shower M. D.

Jan 5<sup>th</sup> 1915 (Address) 3421 Roland Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. Mary's R. Jan 6<sup>th</sup> 1915

## 20-UNDERTAKER

## ADDRESS

A. S. McArthur 3539 Bell Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81649

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *518 Cator Ave* ST. *20* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No.

*518 Cator Ave*

yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Single*

## 6-DATE OF BIRTH

*September 4, 1904*  
(Month) (Day) (Year)

## 7-AGE

*8* yrs. *4* mos. ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,  
(State or Country),*Balto Md*

## 10-NAME OF FATHER

*Chas Meier*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Margaret A. Engel*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ellicott City*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Maggie Meier*

(Address)

*518 Cator Ave*

## 15-

JAN 6 - 1915

Filed

ROBERT J. KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 5, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 10, 1914* to *Jan 5, 1915*that I saw him alive on *Jan 4, 1915*and that death occurred, on the date stated above, at *10 4* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Meningitis*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Howard W. Jones* M. D.*Jan 5, 1915* (Address) *Jennings*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

*London Park Cemetery*

## DATE OF BURIAL

*Jan 8, 1915*

## ADDRESS

*1112 N. B. Dring*

## 20-UNDERTAKER

*Robt J. Turner*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81650

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

105 C81650  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *133 S Broadway*)ST.; *2* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 13.)

## 2-FULL NAME

(Residence in Baltimore: No. *133 S Broadway*)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH,

*aug**31**1895*

(Month)

(Day)

(Year)

## 7-AGE,

*58*

10 LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Iron*  
(b) General nature of industry, business, or establishment in which employed (or employer). *foundry*

## 9-BIRTHPLACE, (State or Country),

*Virginia*

## 10-NAME OF FATHER,

*Chas. H. Young*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Balto Md.*

## 12-MAIDEN NAME OF MOTHER

*Mar. Jane Siler*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Balto Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

JAN 6 - 1915.

ROBERT J. KRAUTER

Filed..... 191.....

SPECIAL PERMIT CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan. - 5**1915*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 26**1914**to Jan 5**1915*that I saw him alive on *Jan 4* *1915*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Chronic Bronchitis*  
*(entero-colitis)*(Duration) yrs. *3* mos. *3* ds.

## CONTRIBUTORY (Secondary)

*General debility*(Duration) yrs. *1* mos. *1* ds.(Signed) *Dr. J. C. Thomas* M. D.*Jan 5*, 1915. (Address) *125 S Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Ave*

## DATE OF BURIAL,

*Jan 7, 1915*

## 20-UNDERTAKER

*Robt J Turner*

## ADDRESS

*1442 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81651

## 1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. 870 Tyson

REGISTERED NO. C

2-FULL NAME Margaret EvansST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 870 TysonSt.: 12 yrs., 1 mos., 0 da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Widow  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

Unknown Unknown 1849  
(Month) (Day) (Year)

7-AGE,

65 yrs., 0 mos., 0 da. IF LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE,

(State or Country),

Ind.

10-NAME OF FATHER,

Kit. Green

11-BIRTHPLACE OF FATHER

(State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Margaret Green

13-BIRTHPLACE OF MOTHER

(State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Keller(Address) 222 W. Monument St.

15-

Filed

JAN 6 - 1915

ROBERT

Burial Per

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 5<sup>th</sup> 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov 9<sup>th</sup> 1914, to Jan 5<sup>th</sup> 1915, that I saw her alive on Jan 2<sup>nd</sup> 1915, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic valv. heart disease  
(fatal in complication)(Duration) 3 yrs., 0 mos., 0 da.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs., 0 mos., 0 da.

(Signed)

Chas. J. Keller M. D.  
Jan 5<sup>th</sup> 1915 (Address) 222 W. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

Jan. 8<sup>th</sup>, 1915

20-UNDERTAKER

Samuel P. Hensby ADDRESS 578 W. Bold St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81652

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81652

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16*)

REGISTERED NO. C

## 2-FULL NAME

Residence in Baltimore: No. *1012 N. Fulton Ave*ST. *16* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

## 6-DATE OF BIRTH.

*1860*  
(Month) (Day) (Year)

## 7-AGE.

*55*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Book keeper.*9-BIRTHPLACE.  
(State or Country).*Md.*

## 10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER  
(State or Country).

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Elin. Ragones*  
(Address) *1012 N. Fulton Ave*JAN 6 - 1915  
Filed..... 1915

ROBERT . KRAUTER,

MUNICIPAL PERMIT CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*Jan 3, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 3, 1915*, to *Jan 4, 1915*, that I saw him alive on *Jan 3, 1915*, and that death occurred, on the date stated above, at *11 A.M.*The CAUSE OF DEATH\* was as follows:  
*Alcoholism*CONTRIBUTORY  
(Secondary)

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

(Signed) *Chas. E. Davis* M. D.  
*Jan 4, 1915* (Address) *1012 N. Fulton Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death? *do not know*Former or usual residence *1012 N. Fulton Ave*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Cathedral**Jan 7, 1915*

## 20-UNDERTAKER

## ADDRESS

*Martin Fatus & Sons 16 Lafayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 N. Broadway ST. 7

## 2-FULL NAME

Charles Reckitt

(Residence in Baltimore: No. 1001 N. Broadway

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

## 6-DATE OF BIRTH

May 11, 1839

## 7-AGE,

75 yrs. 7 mos. 15 ds. If LESS than 1 day, hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country).

Baltimore

## 10-NAME OF FATHER,

Charles Reckitt

## 11-BIRTHPLACE OF FATHER (State or Country).

Maryland

## 12-MAIDEN NAME OF MOTHER

Anna Jenkins

## 13-BIRTHPLACE OF MOTHER (State or Country).

I spent Co

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elias G. Keller

(Address) 1001 N. Broadway

## 15-

JAN 6 - 1915

ROBERT KRASTEN

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 4, 1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 30, 1914, to Jan 4, 1915

that I saw him alive on Jan 3, 1915

and that death occurred, on the date stated above at m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

Heart failure

(Duration) yrs. mos. ds.

(Signed) Arthur W. Gifford M. D.

Jan 1915 (Address) 221 E. Euterpe

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

London Park

## DATE OF BURIAL,

Jan 7, 1915

## 20-UNDERTAKER

Henry Lutz

## ADDRESS

1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81654

## CERTIFICATE OF DEATH.

93 C81654

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 N. Potomac* ST.; *6th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *119 N. Potomac* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

*Married*

6-DATE OF BIRTH,

*Apr*, 184*1*  
(Month) (Day) (Year)

7-AGE,

*73* yrs. *9* mos. ds.If LESS than 1 day.  
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Plumber*  
*Steamfitter*

9-BIRTHPLACE, (State or Country),

*Ind.*

10-NAME OF FATHER,

*Ant. Brown*

11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Ant. Brown*

13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Charles E. Yth*  
*119 N. Potomac St.*

15-

JAN 6 - 1915

ROBERT ZRAUTER,

Filed..... 191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan. 3rd*, 191*5*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan. 1st* 191*5*, to *Jan. 3rd* 191*5*, that I saw him alive on *Jan. 2nd* 191*5*, and that death occurred, on the date stated above, at *8:27* m.

The CAUSE OF DEATH\* was as follows:

*Acute Pleurisy*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Artery* (Duration) *Immediate*(Signed) *J. H. ...* M. D.*1/5/15*, 191... (Address) *2919 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cap. Lounsbury**Jan. 6*, 191*5*

20-UNDERTAKER

ADDRESS

*John A. Moran**Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81655

C81655

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JAN 6 - 1915

ROBERT KRAUTER,

Sur. Gen. Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

Dec. 27, 1914, to Jan 4, 1915,

that I saw him alive on Jan 4, 1915,

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

CONTRIBUTORY (Secondary)

(Signed) W. J. R. R. R.

Jan 4, 1915 (Address) 12008 Colton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer

Jan 6, 1915

20-UNDERTAKER

ADDRESS

Geo M. F. F. F.

811 N Wolfe

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81656

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81656

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1422 Popular Grove* ST.; *16* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1422 Popular Grove* St.; yrs., mos. ds.)

REGISTERED TO C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH

*Unknown*, 1 (Month) (Day) (Year)

## 7-AGE

*22* yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Nore*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *City*

## 10-NAME OF FATHER

*Chas B Shafer*11-BIRTHPLACE OF FATHER (State or Country), *Md*

## 12-MAIDEN NAME OF MOTHER

*Janet Armiger*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Janet Armiger*(Address) *1422 Popular Grove*

JAN 6 - 1915

ROBERT J. KRAUTER,

Filed....., 191

Serial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan*, 191*5* (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan* 191*4*, to *Jan* 191*5*, that I saw her alive on *Jan 3* 191*5*, and that death occurred, on the date stated above, at *59* m.

The CAUSE OF DEATH\* was as follows:

*Myocarditis*(Duration) *1* yrs. mos. ds.CONTRIBUTORY *Acute nephritis* (Secondary)(Duration) *?* yrs. mos. ds.(Signed) *J. Frederick Leit* M. D.*15*, 191*4* (Address) *2040 Entol*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

*Louisa Park*

## DATE OF BURIAL

*Jan 6*, 191*5*

## 20-UNDERTAKER

*W. E. Hickman & Son*

## ADDRESS

*Phoenix Path*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 N Spring ST.; 10 WARD)

## 2-FULL NAME

George Smith(Residence in Baltimore: No. 1226 N Spring

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

Col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH,

Unknown, 1 (Month) (Day) (Year)

## 7-AGE,

57

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Coachman

## 9-BIRTHPLACE, (State or Country),

Baltimore

## PARENTS.

## 10-NAME OF FATHER,

Unknown

## 11-BIRTHPLACE OF FATHER (State or Country),

Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmanuel Dixon(Address) 807 N. Dallas

JAN 6 - 1915

Filed

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 4, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 28 1914, to Jan 4 1915, that I saw him alive on Jan 4 1915, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease(Aortic) associatedwith Asthma with dropsy(Duration) yrs. mos. da. 15

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) W. C. Burns M. D.Jan 4, 1915 (Address) 2218 E. Pratt

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Laurel Home Jan 6, 1915

## 20-UNDERTAKER

## ADDRESS

Harry A. Odgers 1726 E. Union

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Boone ST.: 9 WARD)2-FULL NAME Lorraine Brown(Residence in Baltimore: No. 2631 Boone St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, Col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

10 5, 1913  
(Month) (Day) (Year)

7-AGE,

1 yrs. 2 mos. 29 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....None  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Howard Brown11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Augusta Gassaway13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Brown(Address) 2631 - Boone St.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

1 4, 1915  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Dec. 20 1914, to Jan 4 1915, that I saw her alive on Jan. 4 1915, and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH\* was as follows:

Acute Bronchitis(Duration) yrs. mos. 16 ds.CONTRIBUTORY (Secondary) Diphtheria and general debility(Duration) yrs. mos. 1 ds.(Signed) P. Garland Rhissell, M.D.Jan 5, 1915. (Address) 424 East 23 St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel CemeteryDATE OF BURIAL, Jan 7, 191520-UNDERTAKER Mrs. Joseph S. LockeADDRESS 1723 E. Calver

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 6 - 1915

Filed..... 191. Serial Permit Clerk, Registrar.

ROBERT . KRAUTER,

C81659

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81659

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *854 S. Bond*)ST. *3*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Theodor Groskopf*

Residence in Baltimore: No.

*854 S Bond*St.: *29* yrs. mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

## 6-DATE OF BIRTH,

*December**1857*

(Month)

(Day)

(Year)

## 7-AGE,

*57+*

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Retired Soldier*

(b) General nature of industry, business, or establishment in which employed (or employer).

*Keeper*

## 9-BIRTHPLACE, (State or Country),

*Germany*

## 10-NAME OF FATHER,

*Don't know*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Don't know*

## 12-MAIDEN NAME OF MOTHER

*Don't know*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Don't know*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Clara Groskopf*(Address) *854 S. Bond St.*

## 15-

JAN 6 - 1915

ROBERT KRAUTER

Filed

No.

Serial *Permit* *Clara*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January**4**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 12* 1914, to *January 4* 1915, that I saw him alive on *January 4* 1915, and that death occurred, on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH\* was as follows:

*Chronic barium of liver*(Duration) *4* yrs. *4* mos. *4* da.

## CONTRIBUTORY (Secondary)

*Acute & Chronic*(Signed) *Harry A. Rulberg* M. D.*Jan 4* 1915. (Address) *106 Jackson Pl.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ☒ In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Stanislaw*

## DATE OF BURIAL,

*Jan 8* 1915

## ADDRESS

*405 S. Bond St.*

CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



HEALTH DEPARTMENT—CITY OF BALTIMORE

C81660

C81660

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Fleet

ST.: V WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1907 Fleet St

St.: 21 yrs., 0 mos. 0 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

## 6-DATE OF BIRTH,

Don't Know

(Month)

(Day)

(Year)

## 7-AGE,

73

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer.

## 9-BIRTHPLACE, (State or Country),

German Poland.

## 10-NAME OF FATHER,

Don't Know.

## 11-BIRTHPLACE OF FATHER (State or Country),

German Poland

## 12-MAIDEN NAME OF MOTHER

Don't Know.

## 13-BIRTHPLACE OF MOTHER (State or Country),

German Poland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sleschowski

(Address) 1917 Fleet St.

## 15-

JAN 6 - 1915

ROBERT KRAUTER,

Filed

No.

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

1915, to

1915,

that I saw h alive on

1915,

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH\* was as follows:

Heart Disease

(Duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. J. Valentini

M. D.

1915

(Address)

1800 Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

## DATE OF BURIAL,

Jan. 7, 1915.

## 20-UNDERTAKER

W. F. Sadowski

## ADDRESS

705 S. Am St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81661

C81661

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *24* WARD)2-FULL NAME *James Davis*(Residence in Baltimore: No. *1311 Light St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word.) *Married*6-DATE OF BIRTH, *Unknown*, 18*63*

(Month) (Day) (Year)

7-AGE, *57* yrs., mos., ds.

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Driver*  
(b) General nature of industry, business, or establishment in which employed (or employer). *Ind. Motor Works*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Mr. David*11-BIRTHPLACE OF FATHER (State or Country), *Ind.*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry S. Davis*(Address) *1311 Light St*

## 15-

JAN 6 - 1915

ROBERT J. KRAUTER,

Serial Permit Clerk,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan. 4*, 191*5*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 4* 191*5*, to *Jan 4* 191*5*, that I saw him alive on *Jan 4* 191*5* and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*(Duration) *2 days*CONTRIBUTORY (Secondary) *Acute Carditis*(Duration) *2 days*(Signed) *Edward J. Sullivan, M.D.*(Address) *Mercy Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *13* mos. *11* ds. In the State *Md.*Where was disease contracted, if not at place of death? *1311 Light St*Former or usual residence *1311 Light St*19-PLACE OF BURIAL OR REMOVAL, *St. Anne's Home*DATE OF BURIAL, *Jan 6*, 191*5*20-UNDERTAKER, *Wm. J. Sullivan*ADDRESS *1311 Light St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## C81662 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

103 C81662

## PLACE OF DEATH

CITY OF BALTIMORE (No. 230 N. Carlton

ST. 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Corella Crawford

(Residence in Baltimore: No. 230 N. Carlton

St. 4 yrs., 11 mos. 11 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

6-DATE OF BIRTH,

Feb.

23rd

1867

(Month)

(Day)

(Year)

7-AGE,

48 yrs., 11 mos., 11 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

John Gibson

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER,

Isabella Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Eugene Calhoun

(Address)

230 N. Carlton St.

15-

JAN 6 - 1915

ROBERT KRAUTER,

Serial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan.

3rd

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Gastritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Saml Weinberg M. D.

Jan 4th 1915 (Address) 2302 Madison Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Sauls Cemetery

Jan 6th 1915

20-UNDERTAKER

ADDRESS

Alfred J. Freckler

1111 S. Schuyler



## HEALTH DEPARTMENT---CITY OF BALTIMORE

C81663

## CERTIFICATE OF DEATH

REGISTERED NO. C

C81663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 3)

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and R.N. out No. 18.)

St.; yrs. 7 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, hrs.,  
yrs. 7 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9-BIRTHPLACE  
(State or country)10-NAME OF  
FATHER11-BIRTHPLACE  
OF FATHER  
(State or country)12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from  
Jan 4, 1915, to Jan 5, 1915,  
that I saw her alive on Jan 3, 1915,  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

Contributory  
(SECONDARY)(Signed) J. B. Fredenrath M. D.  
Jan 5, 1915 [Address] 606 Linden St\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

JAN 5 - 1915

UNDERTAKER  
Commons Health.

ADDRESS

FOR ANATOMICAL PURPOSES

Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

JAN 6 - 1915

Filed

191

ROBERT J. JOHNS  
Burial Permit Clerk  
REGISTRAR

UNDERTAKER

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81664

## CERTIFICATE OF DEATH.

C81664

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

## 5-SINGLE,

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

JAN 6 - 1915

ROBERT

JOHNS HOPKINS HOSPITAL

Burial: Robert Clark

## 16-DATE OF DEATH,

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH\* was as follows:

Aortic Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed) Edward P. Smith, M. D.

Jan 2 1915 (Address) Mercy Hosp

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mo. 24 ds. In the State yrs. mo. ds.

Where was disease contracted, if not at place of death? 812 Peach Al.

Former or usual residence 812 Peach Al.

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL

JAN 5 - 1915

## 20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly classified. List statement of OCCUPATION in very important. See instructions on back of certificate.

38.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81665

CERTIFICATE OF DEATH.

C81665

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Josephs Hosp*

ST. *9*

WARD)

FULL NAME

*John Steifel*

(Residence in Baltimore: No. *5 Mile House Hayford Road*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, 1

*Widower*

(Write the word.)

6-DATE OF BIRTH,

*Unknown*

(Month)

(Day)

(Year)

7-AGE,

*72*

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*Hostler*

9-BIRTHPLACE,

(State or Country).

*N.J.*

10-NAME OF FATHER,

*Unknown*

11-BIRTHPLACE OF FATHER

(State or Country),

*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

*JAN 6 - 1915*

*ROBERT*

*Serial Permit*

*State*

*Health*

*FOR ANATOMICAL PURPOSES*

*1915*

*1915*

*1915*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Dec*

*29*

*1914*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

(Inquest, au-

topsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

*Hypostatic Pneumonia*

(Duration) yrs. mos. ds.

CONTRIBUTORY *Accidental fall + fracture of*

(Secondary)

*Right hip*

(Duration) yrs. mos. ds.

(Signed) *Elijah L. Russell* M. D.

(Coroner.)

*Dec 31, 1914* (Address) *423 N. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*HOPKINS HOSPITAL*

*JAN 5 - 1915*

20-UNDERTAKER

ADDRESS

*FOR ANATOMICAL PURPOSES*



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81666

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81666

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 10 yrs. \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 MARRIAGE

Female

White

Widowed

Widowed

6 DATE OF BIRTH

Unknown, 1

7 AGE

60 yrs. \ mos. \ ds.

If LESS than 1 day, \ hrs. or \ min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah Cohen

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Myer Cohen

(Address)

1530 E Pratt St

15

JAN 8 - 1915

HARRY O. ANDREWS

HARRY O. ANDREWS

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6 - 1915

17 I HEREBY CERTIFY, That I attended deceased from

Dec 28, 1914, to Jan 6, 1915,

that I saw him alive on Jan 6, 1915,

and that death occurred, on the date stated above, at 114 m.

The CAUSE OF DEATH\* as follows:

Pneumo-Pneumonia

Contributory (SECONDARY)

(Signed) J. M. O'Brien M. D.

Jan 6, 1915 (Address) 125 S. Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from Violent Causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \ yrs. \ mos. \ ds. In the State \ yrs. \ mos. \ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Rose Cemetery Jan 7, 1915

20 UNDERTAKER

ADDRESS

S. Lunsford Bros Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C81667

PLACE OF DEATH

CITY OF BALTIMORE (No. *1825 Belt Ave.*)

FULL NAME *George W. Thorpe*

(Residence in Baltimore: No. *1825 Belt Ave.*)

REGISTERED NO. C

ST. *9*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH *Aug 15, 1850*  
(Month) (Day) (Year)

7 AGE *64 yrs. 4 mos. 21 ds.* If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Labourer*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Calvert County, Md.*

10 NAME OF FATHER *John Thorpe*

11 BIRTHPLACE OF FATHER (State or country) *Baltimore, Md.*

12 MAIDEN NAME OF MOTHER *Sarah Heath*

13 BIRTHPLACE OF MOTHER (State or country) *England*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Thorpe*

(Address) *1825 Belt Ave.*

15 JAN 6 - 1915  
Filed

HARRY O. ANLBERTS,  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 6, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 3, 1915* to *Jan 4, 1915*, that I saw him alive on *Jan 4, 1915*, and that death occurred, on the date stated above, at *6:18 P.M.* The CAUSE OF DEATH\* was as follows:

*Tuberculosis of the lungs*

*Chloroform*  
(Duration) *2* yrs. — mos. — ds.

Contributory (SECONDARY) (Duration) — yrs. — mos. — ds.

(Signed) *Wm. I. Seaton* M. D.  
*Jan 6, 1915* (Address) *621 E. Fort Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Western Cemetery* *Jan 8, 1915*

20 UNDERTAKER ADDRESS

*Wm. Piquan* *1000 S. Taca*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81668

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81668

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mrs. Clara Mays

Residence in Baltimore: No. Freeland Maryland St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

## 6-DATE OF BIRTH

Feb 10, 1895  
(Month) (Day) (Year)

## 7-AGE

19 yrs. 10 mos. 27 ds.  
If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

## 9-BIRTHPLACE, (State or Country).

Frederick Co Md

## 10-NAME OF FATHER

James Trump

## 11-BIRTHPLACE OF FATHER (State or Country).

Frederick Co Md

## 12-MAIDEN NAME OF MOTHER

Barbara Hunt

## 13-BIRTHPLACE OF MOTHER (State or Country).

Frederick Co Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank J. Mays

(Address)

Freeland Md

## 15-

JAN 6 - 1915

HARRY C. ADAMS,

Filed 191... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Jan 6, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1914, to Jan. 6, 1915, that I saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 2.45 pm. The CAUSE OF DEATH\* was as follows:

Suppurative appendicitis, peritonitis

(Duration) yrs. 1 mos. 12 ds.

## CONTRIBUTORY (Secondary)

Exhaustion

(Duration) yrs. mos. 20 ds.

(Signed) A. Lee Hichew M. D.

1/6/15, 191... (Address) Franklin Sq. Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

At Home

Former or usual residence

Freeland Md.

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

New Freeland P. Co. 7, 1915

## 20-UNDERTAKER

## ADDRESS

W. M. Gaultney 9000 N. Ave. etc

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81669

## CERTIFICATE OF DEATH

28 REGISTERED NO. C

C81669

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-~~SINGLE~~  
MARRIED  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-JAN 6 - 1915

HARRY O. ADAMS,

Barial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h<sup>e</sup> alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death  
Where was disease contracted,  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81670

## CERTIFICATE OF DEATH.

28  
REGISTERED NO. C

C81670

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Brentwood Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1019 Brentwood Ave St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, May 21, 1886 (Month) (Day) (Year)

7-AGE, 28 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Clerk (b) General nature of industry, business, or establishment in which employed, B &amp; O P. O. P.

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Geo. E. Steinmeier

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary P. Mooney

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mary Steinmeier

(Address), 1019 Brentwood Ave

15- JAN 6 - 1915 HARRY O. ANDREWS, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1914, to Jan 5, 1915, that I saw him alive on Jan 4, 1915, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed), W. W. Pearce, M. D. Jan 5, 1915. (Address), 5 E. Pustoon

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan 8, 1915

20-UNDERTAKER

ADDRESS

H. C. Niedeckel 914 Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81671

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *10* ST.; *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore, No. *50* St.; *50* yrs., *50* mos., *50* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, *married*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH

*Unknown*, *1831*  
(Month) (Day) (Year)

## 7-AGE

*84* yrs., *50* mos., *50* ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Natural*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.  
(State or Country).*Ireland*

## 10-NAME OF FATHER

*Don't know*11-BIRTHPLACE OF FATHER  
(State or Country).*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER  
(State or Country).*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sister Benedict*(Address) *Little Sisters of the Poor*

## 15-

Filed

*Jan 6 - 1915*

HARRY O. ANDREWS,

Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 5*, *1915*  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Jan 5*, *1915*, to *Jan 5*, *1915*, that I saw him alive on *Jan 6*, *1915*, and that death occurred, on the date stated above, at *110* m.

The CAUSE OF DEATH\* was as follows:

*Intestinal Obstruction*(Duration) ... yrs. ... mos. *14* ds.

## CONTRIBUTORY (Secondary)

*Strangulated Hernia*  
(Duration) ... yrs. ... mos. *4* ds.(Signed) *Edward J. Johnson**Jan 6*, *1915* (Address) *St. Joseph's Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *50* yrs., *50* mos., *50* ds. In the *50* yrs., *50* mos., *50* ds. State *50* yrs., *50* mos., *50* ds.Where was disease contracted, if not at place of death? *Little Sisters of the Poor*Former or usual residence *Little Sisters of the Poor*

## 19-PLACE OF BURIAL OR REMOVAL.

*Holy Cross* *Jan 7*, *1915*

## 20-UNDERTAKER

*H.C. Wiedefeld 914 Greenmount Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81672

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.;

WARD)

St.; 35 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 6 - 1915

Filed

HARRY O. ALBERT

Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from June 1913, to Jan 8 1915, that I saw her alive on Jan 5 1915, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast

CONTRIBUTORY (Secondary)

Cardiac dilatation  
(Signed) Louis P. Hamburger, M. D.  
Jan 6, 1915 (Address) 1207 Eutan Pl.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

C81673

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81673

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hahnemann Gen. Hosp.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1547 Myrtle Ave* St. *50* yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*male*

## 4-COLOR OR RACE,

*white*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.) *widower*

## 6-DATE OF BIRTH,

*Jan* (Month) *6* (Day), *1844* (Year)

## 7-AGE,

*71*

yrs. mos. da.

## If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Mechanic**Carpenter*9-BIRTHPLACE,  
(State or Country),*Virginia*

## 10-NAME OF FATHER,

*Don't know*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Va*

## 12-MAIDEN NAME OF MOTHER

*Don't know*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Walter Mosher*(Address) *1197 N. Fulton*

## 15-

JAN 6 - 1915

HARRY O. ANDREWS

Filed

191

Burial Permit No.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January* (Month) *5* (Day), *1915* (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 17* 1914, to *January 5* 1914, that I saw him alive on *January 3* 1914, and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH\* was as follows:

*Clinical Diagnosis*  
*Adeno. Carcinoma, of left*  
*Inguinal gland.* (Duration).... yrs. *6* mos. — ds.  
 CONTRIBUTORY *Septic Infection*...  
 (Secondary) (Duration).... yrs. — mos. — ds.  
 (Signed) *Charles E. Clark* M. D.  
 ...., 191... (Address) *1377 N. Gilman*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs. *4* mos. *19* ds. In the State *50* yrs. — mos. — ds.Where was disease contracted, if not at place of death? *1547 Myrtle Ave*Former or usual residence *1547 Myrtle Ave*

## 19-PLACE OF BURIAL OR REMOVAL,

*Landen Park*

## DATE OF BURIAL,

*Jan 7* 1915

## 20-UNDERTAKER

*William Cook*

## ADDRESS

*508 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81674

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2021 Ashton*)

## 2-FULL NAME

(Residence in Baltimore: No. *2021 Ashton St.*)ST.: *70* WARD

St.: — yrs. — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH

*Sept. 14*, 18*93*  
(Month) (Day) (Year)

## 7-AGE

*72* yrs. *4* mos. *4* ds. If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Tailor*  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE.  
(State or Country),*Germany*

## 10-NAME OF FATHER

*Not known*11-BIRTHPLACE OF FATHER  
(State or Country),*Not known*

## 12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER  
(State or Country),*Not known*14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant).....(Address).....*2021 Ashton St.*

## 15-

JAN 6 - 1915

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan. 5*, 191*5*  
(Month) (Day) (Year)17- I HEREBY CERTIFY. That I attended deceased from *Jan. 1*, 191*5*, to *Jan. 5*, 191*5*, and that I saw him alive on *Jan. 5*, 191*5*, and that death occurred, on the date stated above, at *4 P.m.*  
The CAUSE OF DEATH\* was as follows:*Lobar pneumonia*  
(Duration)..... yrs. .... mos. .... ds.  
CONTRIBUTORY (Secondary).....*cardiac failure*  
(Duration)..... yrs. .... mos. .... ds.  
(Signed).....*Dr. Thomas H. Williams* M. D.  
....., 191*5*. (Address).....*345 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death?

Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL

*National City* DATE OF BURIAL.....*Jan. 8*, 191*5*  
20-UNDERTAKER.....*Wm. Cook* ADDRESS.....*5025 North*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81675

## CERTIFICATE OF DEATH.

64

C81675

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1038 Pennsylvania* 17 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1038 Pennsylvania* St.; — yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Married*  
(Write the word.)

## 6-DATE OF BIRTH

*January 1, 1855*  
(Month) (Day) (Year)

## 7-AGE,

*60**0* yrs. *4* mos. *4* ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*none*9-BIRTHPLACE,  
(State or Country),*md*

## 10-NAME OF FATHER,

*Patrick Hughes*11-BIRTHPLACE OF FATHER  
(State or Country),*Ireland*

## 12-MAIDEN NAME OF MOTHER

*William*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Emma Hughes*

(Address)

*1038 Pennsylvania*

## 15-

JAN 6 - 1915

Filed

191

HARRY C. ANDREWS,

Corial Permit to Clar Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 5, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Dec 23* 191*4*, to *Jan 5* 191*5*,  
that I saw him alive on *Jan 5* 191*5*,  
and that death occurred, on the date stated above, at *9a.* m.

The CAUSE OF DEATH\* was as follows:

*Arterial Haemorrhage*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *William E. Burton* M. D.*Jan 5, 1915* (Address) *762 Dolphin*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore*

## DATE OF BURIAL,

*Jan 6, 1915*

## 20-UNDERTAKER

*Wm. Boas*

## ADDRESS

*502 E. N. Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81676

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81676

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

4007 Maine Av Forest Park

ST. 15 WARD)

2-FULL NAME

William Mynde

(Residence in Baltimore: No.

4007 Maine Av Forest Park

St.: 83 yrs.

mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

6

5

1831

7-AGE

83

yrs. 7 mos. ds.

If LESS than  
1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Retiree

9-BIRTHPLACE  
(State or country)

England

10-NAME OF  
FATHER

William Mynde

11-BIRTHPLACE  
OF FATHER  
(State or country)

England

12-MAIDEN NAME  
OF MOTHER

Ann Griffiths

13-BIRTHPLACE  
OF MOTHER  
(State or country)

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James C. Mynde

(Address)

4007 Maine Av.

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 27, 1914 to Jan 5, 1915.

that I saw him alive on Jan 5, 1915.

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Rectum

Clinical diagnosis

About

(Duration)

yrs. 7

mos.

ds.

Contributory  
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Jan 6, 1915 (Address) 2038 Madison Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,  
or Recent Residents)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Park Cem

Jan 8, 1915

20-UNDERTAKER

ADDRESS

Joseph J. Cook

1003 N. Bell

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 6 - 1915

HARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81677

HEALTH DEPARTMENT—CITY OF BALTIMORE

156

C81677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin Square Hosp. 18*)

2-FULL NAME *John Frederick Villmar*

(Residence in Baltimore: No. *78 Arlington Ave*)

3-SEX, *male*

4-COLOR OR RACE, *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*  
(Write the word.)

6-DATE OF BIRTH, *Feb. 8<sup>th</sup>, 1858*  
(Month) (Day) (Year)

7-AGE, *56 yrs. 10 mos. 27 ds.*  
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Tailor*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *F. Frederick Villmar*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Henry F. Villmar*  
(Address) *78 Arlington Ave*

15-

JAN 6 - 1915

HARRY O. ASHLEY, Clerk

Serial Permit

191

Registrar.

16-DATE OF DEATH, *Jan. 4<sup>th</sup>, 1915*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:  
*Asphyxia by gas*  
*Suicide*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.  
(Signed) *Sam'l. H. H. H. M. D.* (Coroner)  
*Jan 4<sup>th</sup>, 1915* (Address) *2302 Madison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death? ...  
*78 Arlington Ave*  
Former or usual residence *78 Arlington Ave*

19-PLACE OF BURIAL OR REMOVAL, *Bellvue Cem.* DATE OF BURIAL, *Jan 7, 1915*  
ADDRESS *1003 N. Caloss*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81678

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81678

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JAN 7 - 1915

ROBERT KRAUTH  
Serial Death Clerk  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY. That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081679

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Josephs Hosp* St. WARD)

2-FULL NAME *Robert J. Biggs*

(Residence in Baltimore: No. *930 N Fulton Ave* St.; yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*Sept* (Month)

*25* (Day)

*1872* (Year)

7-AGE,

*42* yrs.

*3* mos.

*11* da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Cook Helper*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

*Ind*

10-NAME OF FATHER,

*Wm Biggs*

11-BIRTHPLACE OF FATHER (State or Country),

*Ind*

12-MAIDEN NAME OF MOTHER

*Sarah Green*

13-BIRTHPLACE OF MOTHER (State or Country),

*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. J. Krauter*

(Address) *North Pen Ave*

15-

JAN 7 - 1915

ROBERT J. KRAUTER,

Serials Clerk.

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan* (Month)

*5* (Day)

*1915* (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the *day* stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*

(Duration) *Chronic* yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) *Chronic* yrs. mos. da.

(Signed) *Elyah J. Russell* M. D.

*Jan 6, 1915* (Address) *423 N Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *See way to Hosp* of death *Jan 5* yrs. mos. da. State *Ind* yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Marys Bridge Care Jan 7, 1915*

20-UNDERTAKER

ADDRESS

*W. J. Krauter North Pen Ave*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81680

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81680

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *238 S. Patterson Park Dr.* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *238 S. Patterson Park Dr.* St. *52* yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Married*

## 6-DATE OF BIRTH,

*July 24, 1892*  
(Month) (Day) (Year)

## 7-AGE,

*82 yrs. 5 mos. 12 ds.*If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of *captain*  
(b) General nature of industry, business,  
or establishment in which  
employed (or employer) *retired*9-BIRTHPLACE,  
(State or Country),*Germany*  
10-NAME OF FATHER, *Jymen Wiver*11-BIRTHPLACE  
OF FATHER  
(State or Country),*Germany*  
12-MAIDEN NAME  
OF MOTHER, *Henriette Folgers*13-BIRTHPLACE  
OF MOTHER  
(State or Country),*Germany*  
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.(Informant) *Augusta Wiver*(Address) *238 S. Patterson Park Dr.*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 6, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Jan 5 - 1915*, to *Jan 6 - 1915*,  
that I saw him alive on *Jan 6 1915*,  
and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*(Duration) ... yrs. ... mos. *3* ds.CONTRIBUTORY *Senility - Cardiac*  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Immanuel Emich* M. D.*Jan 7, 1915* (Address) *125 S. B. Hwy*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL,

*Immanuel Emich* *Jan 10, 1915*

## 20-UNDERTAKER

## ADDRESS

*Lois Heemann* *32 S. B. Hwy*

## 15-

JAN 7 - 1915

ROBERT KRAUTER

Filed *1915* Registrar

N. B.—Every item of information should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81681

## CERTIFICATE OF DEATH.

C81681

PLACE OF DEATH

CITY OF BALTIMORE: (No. *318 S. Morris ally* 19 WARD)

FULL NAME *Helena Yankov*

(Residence in Baltimore: No. *318 S. Morris ally* St.; yrs. mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *single* (Write the word.)

6-DATE OF BIRTH, *Dec 6, 1914* (Month) (Day) (Year)

7-AGE, yrs. mos. *31* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *John Yankov*

11-BIRTHPLACE OF FATHER (State or Country), *Hungary*

12-MAIDEN NAME OF MOTHER *not known*

13-BIRTHPLACE OF MOTHER (State or Country), *Hungary*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. H. Freeman*

(Address) *Community Hospital*

16-JAN 7 - 1915 ROBERT KRAUTER

Filed *191* Serial *10000* Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 6, 1915* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 2 1915* to *Jan 5 1915*, that I saw her alive on *Jan 5 1915*, and that death occurred, on the date stated above, at *12:45* m.

The CAUSE OF DEATH\* was as follows:

*Septicemia (Streptococcus)*

(Duration) yrs. mos. *21* ds.

CONTRIBUTORY (Secondary) *infected umbilical cord*

(Duration) yrs. mos. *31* ds.

(Signed) *W. H. Freeman* M. D.

191... (Address) *Community Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*New Catholic Cem.* *Jan 7, 1915*

20-UNDERTAKER ADDRESS

*John J. Childs 1240 34th St. and d*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CS1682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156CS1682

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 813 N. Brice st.

16 St.: WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel T. Lea,

(Residence in Baltimore: No. 813 N. Brice st.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, May 31st, 1890. (Month) (Day) (Year)

7-AGE, 24 yrs. 7 mos. 5 ds. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Conductor, (b) General nature of industry, business, or establishment in which employed (or employer), Street cars.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Samuel T. Lea,

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Isabelle Barnitz,

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob W. Traube,

(Address) 813 N. Brice street.

15- JAN 7 - 1915

Filed, 1915, Robert Krauth, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Asphyxiation by illuminating gas, (suicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Humpal M. D.

(Coroner.)

Jan. 6th, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

H. Christ, Undertaker

Jan. 8, 1915

ADDRESS

Jessie Syfer

1600 W. North ave



## HEALTH DEPARTMENT—CITY OF BALTIMORE

81683

## CERTIFICATE OF DEATH.

28 C81683

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1507 Mc. Henry ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Francis M. Keefer  
(Residence in Baltimore: No. 1507 Mc. Henry St., 57 yrs., 10 mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

March 5<sup>th</sup>, 1857  
(Month) (Day) (Year)

7-AGE,

57 yrs., 10 mos., 1 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Upholster

9-BIRTHPLACE,

(State or Country).

Baltimore City

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

Jonathan Keefer

Virginia

Mary Zeigler

Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

Charles R. Keefer

678 W. Bonre St.

15 JAN 7 - 1915

ROBERT KRAUTER,

Serial Permit Clerk

Filed....., 1915

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 6, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 14, 1914, to Jan 6, 1915,

that I saw him alive on Jan 5, 1915,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, tubercular

(Duration) 4 yrs., 4 mos., ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs., mos., ds.

(Signed) H. E. Smith M. D.

Jan 6, 1915. (Address) 1002 W. Lanrad

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Mt. Olivet Cem. Jan. 7, 1915

Philip Seewald &amp; Son 1905 E. Putnam St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

C81684

## HEALTH DEPARTMENT—CITY OF BALTIMORE

79 C81684

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1141 W. Franklin St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1141 W. Franklin St.

St. 35 yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH

Mich. 28th, 1848

## 7-AGE

66 yrs. 9 mos. 8 ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe maker

## 9-BIRTHPLACE, (State or Country),

Germany

## 10-NAME OF FATHER,

Frederick Rudolph

## 11-BIRTHPLACE OF FATHER (State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Not known

## 13-BIRTHPLACE OF MOTHER (State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Herschman

(Address) 1141 W. Franklin St.

## 15-

JAN 7 - 1915

Filed.....

ROBERT KRAUTH

MAR 11 1915

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 5, 1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec. 28 1914, to Jan. 5 1915.

that I saw him alive on Jan. 5 1915,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Disease

(Duration) 9 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) J. S. Shippey, M.D.

Jan. 5, 1915 (Address) 206 W. Franklin St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

London Park Cem.

## DATE OF BURIAL

Jan. 7, 1915.

ADDRESS

Philip Seewald &amp; Son 119 S. Eutan St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81685

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5* ST.; *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Anderson*(Residence in Baltimore: No. *1101 Thompson St.* St.; *5* yrs., *5* mos. *5* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*Black*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Married*

6-DATE OF BIRTH,

*Unknown**1869*

(Month)

(Day)

(Year)

7-AGE,

*45*

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housework*

9-BIRTHPLACE,

(State or Country),

*Maryland*

10-NAME OF FATHER,

*Unknown*

11-BIRTHPLACE OF FATHER

(State or Country),

*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. B. Curry*(Address) *1101 Thompson St.*

15-

JAN 7 - 1915.

Filed

ROBERT . KRAUTH

SARIAL BIRTH CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan*

(Month)

*5*

(Day)

*1915*

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 3* 1915 to *Jan 5* 1915,that I saw her alive on *Jan 5* 1915,and that death occurred, on the date stated above, at *4:15* p. m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(Duration) *3* yrs. *5* mos. *5* da.CONTRIBUTORY *Cerebral arteriosclerosis*

(Secondary)

(Duration) *5* yrs. *7* mos. *7* da.(Signed) *Wm. A. Hodge* M. D.*Jan 5, 1915* (Address) *1101 Thompson St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* da. In the State yrs. mos. *Unknown*Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *1101 Thompson St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Paul. Cemetery* *Jan 8, 1915*ADDRESS *Robert. Ch. Elliott**506 E. Fayette St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81686

## CERTIFICATE OF DEATH.

167 C81686  
REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD) •

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

JAN 7 - 1915

Serial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

1d-DATE OF DEATH,

January 6, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that the cause of death was as follows:

thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
Accident - Burn of body.  
"Playing with low fire.  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Signed) Thos. H. Krauter, M. D.  
(Coroner)  
Jan. 7, 1915. (Address) 18 N. Franklin St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

723 Harvey St.  
Former or usual residence 723 Harvey St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Old St. Luke's Church

Feb. 7, 1915

20-UNDERTAKER

ADDRESS

Wm. Cook

5024 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81687

C81687

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. \_\_\_\_\_ ST.; \_\_\_\_\_ WARD)

## 2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_ St.; \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ ds.)

REGISTERED NO. C \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

## 6-DATE OF BIRTH,

Dec 6, 1848  
(Month) (Day) (Year)

## 7-AGE,

72 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

Gardener

9-BIRTHPLACE,  
(State or Country),

Germany

## 10-NAME OF FATHER,

John Barthel

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

JAN 7 - 1915

Filed \_\_\_\_\_

191

ROBERT KRAUTH,

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 4, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1915, to Jan 4 1915, that I saw him alive on Jan 4 1915, and that death occurred, on the date stated above, at 1:55 P.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
and Acute Nephritis  
(Duration) ... yrs. ... mos. 2 ds.CONTRIBUTORY  
(Secondary)Cystitis (Acute)  
(Duration) ... yrs. ... mos. 7 ds.  
(Signed) R. L. Johnson M. D.

Jan 7, 1915. (Address) University Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs. — mos. 2 ds. In the State 25 yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

630 S. Monroe St

## 19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

## DATE OF BURIAL,

Jan 7, 1915

## ADDRESS

215 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

C81688

## HEALTH DEPARTMENT—CITY OF BALTIMORE

. 91 C81688

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1500 N. Rose*ST.: *8*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George J. Kenner*Residence in Baltimore: No. *1500 N. Rose*St.: *1* yrs., *11* mos. *27* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)*Single*

## 6-DATE OF BIRTH.

*January 9, 1913*  
(Month) (Day) (Year)

## 7-AGE.

*1* yrs., *11* mos., *27* ds.

If LESS than 1 day.

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*nurse*9-BIRTHPLACE,  
(State or Country).*Balls. Md.*

## PARENTS.

## 10-NAME OF FATHER.

*George Kenner*11-BIRTHPLACE OF FATHER  
(State or Country).*Balls. Md.*

## 12-MAIDEN NAME OF MOTHER

*Mathilda Ginkand*13-BIRTHPLACE OF MOTHER  
(State or Country).*Balls. Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mr. George Kenner*

(Address)

*1500 N. Rose St.*

## 15-

Filed

*JAN 7 - 1915*

ROBERT J. KRAJICEK

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*Jan 6, 1915*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Jan 2* 1915, to *Jan 6* 1915, that I saw her alive on *Jan 5* 1915, and that death occurred, on the date stated above, at *12:30* p.m.

The CAUSE OF DEATH\* was as follows:

*Bronchitis Pneumonia*(Duration) ... yrs. ... mos. *5* ds.CONTRIBUTORY  
(Secondary)*Bronchitis Pneumonia*(Duration) ... yrs. ... mos. *5* ds.

(Signed)

*H. Powers*

M. D.

*Jan 7, 1915* (Address) *2511 E. Pratt St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

*New Cathedral Cemetery*

## DATE OF BURIAL.

*Jan 8, 1915*

## ADDRESS

*1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81689

## CERTIFICATE OF DEATH.

108 C81689

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp.* ST.; *6* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1700 E. Balto St.*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *8* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH

*Jan*, 1875 *Dec 25* 1914 to *Jan 7* 1915  
(Month) (Day) (Year)

## 7-AGE,

*40* yrs. — mos. — ds.

## If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cabinet-maker*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

*Russia*

## 10-NAME OF FATHER,

*Unknown*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Russia*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Russia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. O. Curry*(Address) *1700 E. Balto St.*15- *JAN 7 - 1915* *JOSEPH V. KRATZER,*Filed. 191. *Serial Permit Clerk.*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan*, 1915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on *Jan* 1915and that death occurred, on the date stated above, at *2.55 p.m.*

The CAUSE OF DEATH\* was as follows:

*Acute Appendicitis with perforation*(Duration) yrs. — mos. — ds. *7*CONTRIBUTORY (Secondary) *Bronchitis*(Duration) yrs. — mos. — ds. *2*(Signed) *Judith Zader* M. D.*Jan 7*, 1915 (Address) *1700 E. Balto St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. — mos. — ds. *12* In the State yrs. — mos. — ds. *Unknown*Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *1700 E. Balto St.*

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Hebrew Washington* *Jan 7*, 191520-UNDERTAKER ADDRESS *Jack Lurs* *14195 Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81690

## CERTIFICATE OF DEATH

C81690

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1650 E. Fayette St. ST. 6. WARD)

2-FULL NAME Abraham Wenz

(Residence in Baltimore: No. 1650 E. Fayette St. 8 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH Jan, 1866 (Month) (Day) (Year)

7 AGE 49 yrs. mos. ds. or min. 2 If LESS than 1 day, hrs.

8 OCCUPATION Retired Merchant (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER Isaac Wenz

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Cohen

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis (Address) 1419 E. Baltimore St.

15. JAN 7 - 1915 ROBERT KRAUTER, Permit Clerk REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 6, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1915, to Jan. 6, 1915, that I saw him alive on Jan 6, 1915, and that death occurred, on the date stated above, at 11:00 P.M. The CAUSE OF DEATH was as follows:

Carcinoma of Larynx (Radium used)

(Duration) 3 yrs. mos. ds. Contributory Pneumonia after Tracheotomy (SECONDARY)

(Signed) Joseph L. Kemler M. D. (Address) 1908 E. Baltimore Pl.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Cemetery DATE OF BURIAL Jan 7, 1915

20-UNDERTAKER Jack Lewis ADDRESS 1419 E. Baltimore St.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C81691

PLACE OF DEATH

CITY OF BALTIMORE (No. 328 S. Dallas St.)

FULL NAME Elmer A. Trusty

(Residence in Baltimore: No. 328 S. Dallas

3

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Sept 12, 1913 (Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. 29 ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, George Trusty

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Vera Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) George Trusty (Address) 328 S. Dallas St.

15- JAN 7 - 1915 Filled JAN 7 1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1916 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough (Duration) yrs. mos. ds.

(Signed) J. W. Jones, M. D. (Coroner) Jan 6, 1916 (Address) 3116 S. Journal St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cemetery DATE OF BURIAL, Jan 7, 1916

20-UNDERTAKER, Harry A. Voderberg ADDRESS, 1720 E. Calver

C81692

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81692

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

ROBERT . KRAUTER,

Burial Permit Clerk

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

January 4, 1915, to, January 6, 1915,

that I saw him alive on, January 6, 1915,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Henry J. Hahn

January 6, 1915, [Address] 508 Park Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,

OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery 1/8/1915

20-UNDERTAKER

F. B. Huppert 2238 Fred. L. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81693

64 C81693

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

1702 Byrd

ST.:

24

WARD)

REGISTERED NO. C

## 2. FULL NAME

Mary. M. Weigand

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1702 Byrd

St.:

yrs.

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6. DATE OF BIRTH,

April 22nd, 1864

(Month)

(Day)

(Year)

## 7. AGE,

50 yrs. 8 mos. 15 ds.

IF LESS than 1 day.

hrs. or min.

## 8. OCCUPATION:

(a) Trade, profession, or particular kind of work.

House Work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At home.

## 9. BIRTHPLACE,

(State or Country),

Baltimore Md.

## PARENTS.

## 10. NAME OF FATHER,

Martin Fisher

## 11. BIRTHPLACE OF FATHER

(State or Country),

Germany

## 12. MAIDEN NAME OF MOTHER

Elizabeth Fisher

## 13. BIRTHPLACE OF MOTHER

(State or Country),

Germany

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Michael Weigand.

(Address)

1702 Byrd St

JAN 7 - 1915

ROBERT KRAUTER

Filed.

191

Burial Record Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH,

January 6, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Dec 23

1914

to Jan 6

1915

that I saw him alive on

Jan 5

1915

and that death occurred, on the date stated above, at

3:55 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

## CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Frederick J. O'Brien M. D.

Jan 7, 1915 (Address) 7527 Calver St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Holy Redeemer

Jan 9, 1915

## UNDERTAKER

## ADDRESS

E. B. Harle

1158 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81694

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

79 C81694  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 Tatapsee

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Herman A. Ruppert

(Residence in Baltimore: No. 1224 Tatapsee

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Single

## 6-DATE OF BIRTH,

November 24<sup>th</sup>, 1890  
(Month) (Day) (Year)

## 7-AGE,

24 yrs. 1 mos. 13 ds.

10 LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Glaser

9-BIRTHPLACE,  
(State or Country),

Baltimore Md.

## PARENTS.

## 10-NAME OF FATHER,

Frederick L. Ruppert

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore Md.

## 12-MAIDEN NAME OF MOTHER

Annie B. Wagner

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick L. Ruppert

(Address) 1224 Tatapsee St

15-JAN 7 - 1915

ROBERT KRAUTER

Filed..... 191

SARIEL PERKINS Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 6<sup>th</sup>, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 15<sup>th</sup> 1914, to Jan 5<sup>th</sup> 1915, that I saw him alive on Jan 5 1915, and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency  
Personal Knowledge (Duration) 3 yrs. mos. ds.CONTRIBUTORY  
(Secondary)(Duration) 3 yrs. mos. ds.  
(Signed) Henry B. Kall M. D.  
Jan 6<sup>th</sup> 1915 (Address) 1203 Light St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

## DATE OF BURIAL,

1-8-1915

## 20-UNDERTAKER

E. B. Harle

## ADDRESS

115 E. West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81695

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

CERTIFICATE OF DEATH.

C81695

PLACE OF DEATH

CITY OF BALTIMORE (No. 2148 DIVISION STREET, ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME HENRY W. STANLEY,

(Residence in Baltimore: No. 2148 DIVISION STREET, St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Divorced, (Write the word.)

6-DATE OF BIRTH, Could not ascertain, / (Month) (Day) (Year)

7-AGE, 49? yrs. ? mos. ? ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Provision (b) General nature of industry, business, or establishment in which employed (or employer) huckster.

9-BIRTHPLACE, (State or Country), Virginia,

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) No informant.

(Address) .....

15- JAN 7 - 1915 ROBERT K. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, au- topsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis, (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds. (Signed) J. Frederick Campbell M. D. (Coroner.)

Jan. 7th, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Maurice DATE OF BURIAL, Jan 10th, 1915

UNDERTAKER Charles Campbell ADDRESS 1364 Meade

C81696

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81696

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 7 - 1915

BARRY O. AYLWARD,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

1-7-1915 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKEN

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81697

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81697

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *William H. Little*(Residence in Baltimore: No. *821 Belvidere Ave* St.; *70* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (If in the world.) *Widowed*6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *75*

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Painter*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Penna.*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record of Mercy*(Address) *Hospital*15-*JAN 7 - 1915*

HARRY O. ARDRETS

Filed *1915* Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Dec 31, 1914*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec 30* 1914, to *Dec 31* 1914,that I saw him alive on *Dec 31* 1914,and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Myocarditis*  
(Duration) *Don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *Don't know* yrs. mos. ds.  
(Signed) *Edward Smith* M. D.  
*Dec 31* 1914 (Address) *Mercy Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State *70* yrs. mos. ds.Where was disease contracted if not at place of death? *Don't know*Former or usual residence *821 Belvidere Ave*19-PLACE OF BURIAL OR REMOVAL, *National Cem.*DATE OF BURIAL, *Jan 8, 1915*20-UNDERTAKER *John E. Hughes*ADDRESS *1422 Penna Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81698

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81698

### PLACE OF DEATH

CITY OF BALTIMORE (No. 1814 N. PAYSON ST. ST. 15 WARD)

### FULL NAME

LOUISE WALLACE,

(Residence in Baltimore: No. 1814 N. PAYSON ST.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 1-SEX,

Female,

#### 4-COLOR OR RACE,

White,

#### 5-SINGLE,

MARRIED, Widowed,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

#### 6-DATE OF BIRTH,

April 2nd, 1854.  
(Month) (Day) (Year)

#### 7-AGE,

60 yrs. 10 mos. 4 ds.

#### If LESS than 1 day,

hrs. or min.

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

#### 9-BIRTHPLACE,

(State or Country),

Germany,

#### 10-NAME OF FATHER,

John Felt,

#### 11-BIRTHPLACE OF FATHER

(State or Country),

Germany,

#### 12-MAIDEN NAME OF MOTHER

Unknown,

#### 13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown.

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred R. Wallace.

(Address) 1814 N. Payson street.

JAN 7 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

January 6th, 1915.  
(Month) (Day) (Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said  
(Inquest, au-

inquiry find that said deceased came to her death  
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Acute cardiac dilatation.

(Duration) yrs. mos. ds.

CONTRIBUTORY Pulmonary congestion

(Secondary)

et oedema. (Duration) yrs. mos. ds.

(Signed) J. Frederick Kumpel M. D.  
(Coroner)

Jan. 7th, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

Baltimore

Jan 8, 1915

#### 20-UNDERTAKER,

#### ADDRESS

H. McKnetts

Remond Path



C81699

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81699

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 62 yrs. ? mos. ? ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.  
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JAN 7 - 1915.

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Rectum

Chronic dysentery

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY.. Cachexia, cardiac

(Secondary) Failure

(Duration) yrs. 15 mos. ds.

(Signed) Harry O. Andrews M. D.

Jan 7, 1915 (Address) 214 E. Preston St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery Jan 9, 1915

20-UNDERTAKER

ADDRESS

Stewart &amp; Warren Co 108 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81700

30

C81700

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: *Maryland General Hospital* ST.;

REGISTERED NO. C

WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Albert E. Phillips*

Residence in Baltimore: No.

*620 St Ann's Ave*

St.; - yrs., - mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*male*

## 4-COLOR OR RACE,

*white*

## 5-SINGLE,

*single*~~MARRIED,~~~~WIDOWED,~~~~OR DIVORCED,~~

(Write the word.)

## 6-DATE OF BIRTH,

*July**15*

(Month)

(Day)

(Year)

## 7-AGE,

*4*

yrs.

*6*

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Child*

## 9-BIRTHPLACE,

(State or Country),

*Ind*

## 10-NAME OF FATHER,

*Albert E. Phillips*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Maryland*

## 12-MAIDEN NAME OF MOTHER

*Ida Clary*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Ida Phillips*

(Address)

*620 St Ann's Ave*

15- JAN 7 - 1915

HARRY O. ANDREWS,

Filed.....

191

Barial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*

(Month)

*6*, 191*5*

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 1* 191*5*, to *Jan 6* 191*5*,that I saw him alive on *Jan 6* 191*5*,and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Subacute meningitis*(Duration)..... yrs. .... mos. *15* ds.

## CONTRIBUTORY

(Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed) *Chas. C. Ayres* M. D.*1/6/* 191*5* (Address) *Md. General Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death - yrs. - mos. *6* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *620 St Ann's Ave*

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Mt Carey Md Jan 9* 191*5*

## 20-UNDERTAKER

## ADDRESS

*William Cook* *507 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1725

2-FULL NAME

(Residence in Baltimore: No. 1725 Hope St.)

Mercy Hospital  
John M. Douglass  
1725 Hope St.

ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH,

January 10<sup>th</sup>, 1848  
(Month) (Day) (Year)

7-AGE,

67

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cab-driver

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Joseph Douglass

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Harriet Baudett

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Joseph P. Douglass  
1312 Washington

15-

JAN 7 - 1915

HARRY O. ANDREWS,

191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 5<sup>th</sup>, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Fractured Skull  
Cause unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sub. Odema of Lungs

(Duration) yrs. mos. ds.

(Signed) Wm. M. Savage, M. D. (Coroner.)

Jan. 8, 1915. (Address) 1729 Madison Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1725 Hope St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cemetery Jan. 8, 1915

20-UNDERTAKER ADDRESS

Henry Dock Sen 1301 E Bay St



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81702

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 REGISTERED NO. C

C81702

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

225 W. Henrietta  
Wm F Taylor  
225 W. Henrietta

WARD)

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Male Colored

Married

6-DATE OF BIRTH

Unknown, 1846  
(Month) (Day) (Year)

7-AGE

68

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Meat dealer

9-BIRTHPLACE (State or country)

Md

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Taylor

(Address)

225 W. Henrietta St

15-JAN 7 - 1915

HARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 5, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1914, to Jan 5, 1915.

that I saw him alive on Jan 5, 1915.

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH\* was as follows:

Coronary Disease

(Duration) yrs. 1 mos. 5 ds

Contributory (SECONDARY)

Heart Failure

(Duration) yrs. 1 mos. 5 ds

(Signed),

C. H. Finner

M. D.

Jan 7, 1915

(Address) 714 S. North Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn Cem

DATE OF BURIAL

Jan 8, 1915

ADDRESS

142 W. Hill St



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81703

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

77

C81703

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow. 6-DATE OF BIRTH Febry 1828 (Month) (Day) (Year)

7-AGE 87 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15-

JAN 7 - 1915

HARRY O. ASHREWS,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 6, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1914, to Jan 6, 1915, that I saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 6 p. m. The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 15 yrs. 7 mos. 14 ds. In the 87 yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81704

C81704

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1804 Ashburton, St. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No.

Annie E. Riley

1804 Ashburton

St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

## 6-DATE OF BIRTH.

Oct. 11, 1886

## 7-AGE

78 yrs. 2 mos. 26 ds.

If LESS than 1 day, ... hrs. or ... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE.  
(State or Country).

City

## 10-NAME OF FATHER.

Jno. B. Moody

## 11-BIRTHPLACE OF FATHER

(State or Country).

City

## 12-MAIDEN NAME OF MOTHER

Mary E. Ward

## 13-BIRTHPLACE OF MOTHER

(State or Country).

City

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Laura Moody

1804 Ashburton

## 15-

JAN 7 - 1915

Filed

191

Burial Permit

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

January 6, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1914, to Jan 6, 1915, that I saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal  
Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. N. McLaughlin M. D.

Jan 1, 1915 (Address) 1415 Linden

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Green Mt.

## DATE OF BURIAL.

Jan 1, 1915

## 20-UNDERTAKER

W. J. McLaughlin

## ADDRESS

Northan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. McLaughlin  
1415 Linden Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81705

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81705

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *Unknown*, 1 (Month) (Day) (Year)

7-AGE *22* yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work *Artist* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *New York*

10-NAME OF FATHER *Unknown*

11-BIRTHPLACE OF FATHER (State or country) *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Burger*

(Address) *703 Balboe St.*

JAN 8 - 1915

Filed

ROBERT J. KRAUTER, Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan. 7, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *Dec. 15, 1914* to *Jan. 7, 1915* that I saw her alive on *Jan. 7, 1915* and that death occurred, on the date stated above, at *6:20 P.M.* The CAUSE OF DEATH\* was as follows:

*Central Syphilis*

Contributory (SECONDARY) *Paralysis of hand* (Duration) yrs. mos. ds. *20*

(Signed) *Henry H. Weinger* M. D. *Jan. 7, 1915* (Address) *724 W. Fayette St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence *703 Balboe St.*

19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *Jan 9, 1915*

20-UNDERTAKER *Fahnestock Co* ADDRESS *166 Madison Ave*

## C81706 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 Elgin Ave.,

ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron C. Lauer,

Residence in Baltimore: No. 3226 Elgin Ave.,

St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, white, 5-SINGLE, MARRIED, single, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Jan. 10th, 1851 (Month) (Day) (Year)

7-AGE, 63 yrs. 11 mos. 26 ds. It LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Retired, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.,

10-NAME OF FATHER, Lewis Lauer,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Sarah Bamberger,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Hollander,

(Address) 3226 Elgin Ave.

JAN 8 - 1915. ROBERT KRAUTER, Marial Permit Clerk, Filed 1915 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH, Jan. 6th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1914, to January 1915, that I saw him alive on January 6 1915, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis - death in an attack of Angina.

(Duration) Not known (many) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Arteriosclerosis

(Duration) Not known yrs. mos. ds.

(Signed) Sydney A. Miller M. D.

Jan 6, 1915. (Address) Elgin Ave 3226 St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Har Sinai,

DATE OF BURIAL,

Jan. 8th 1915.

20-UNDERTAKER

Band Sontheimer 1000 1st St

ADDRESS



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81707

41 C81707

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 W. Lombard

ST. 18 WARD)

REGISTERED NO. C

## 2-FULL NAME

John C Roehner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1219 W Lombard

St.; 51 yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
Married

## 6-DATE OF BIRTH,

Sept 21, 1846  
(Month) (Day) (Year)

## 7-AGE,

74 yrs. 3 mos. 10 ds.

If LESS than 1 day,  
...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer).

Shoe Maker

9-BIRTHPLACE,  
(State or Country).

Germany

10-NAME OF  
FATHER

Fred Roehner

11-BIRTHPLACE  
OF FATHER  
(State or Country).

Germany

12-MAIDEN NAME  
OF MOTHER

Unknown

13-BIRTHPLACE  
OF MOTHER  
(State or Country).

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jm. D. Roehner

(Address)

1219 W. Lombard St.

## 15-

JAN 8 - 1915

Filed 191

ROBERT . KRAUTER

Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jany 7<sup>th</sup>, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
1912, to Jany 7 1915,  
that I saw him alive on Jany 5 1915,  
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma Intestinalis  
with probable metastasis to lungs  
(to post mortem was made)  
(Duration) 4 to 6 mos. ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Pearce Kutzin M. D.

Jany. 8., 1915 (Address) 1321 S. Charles St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Sondam Park Jan 10, 1915

## 20-UNDERTAKER

## ADDRESS

Geo. H. Little 531 N. Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT - CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

74 C81708

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S. Broadway ST.; 3 WARD)

2-FULL NAME *Joseph H. Coley*  
(Residence in Baltimore: No. 133 S. Broadway St.; unknown yrs., mos., da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

*Married*

6-DATE OF BIRTH,

*Apr 12, 1856*  
(Month) (Day) (Year)

7-AGE,

*58 yrs., 8 mos., 25 da.*  
If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Cushman*

9-BIRTHPLACE,  
(State or Country),

*France*

10-NAME OF FATHER,

*Unknown*

11-BIRTHPLACE OF FATHER  
(State or Country),

*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER  
(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): *Elise Coley*

(Address): *133 S. Broadway*

15- JAN 8 - 1915

ROBERT KRAUTER

Serial Permit Clerk

Registrar

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 6, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 9, 1914*, to *Jan 6, 1915*, that I saw him alive on *Jan 6, 1915*, and that death occurred, on the date stated above, at *3:12 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Tumor*

(Duration) *exactly unknown* yrs., mos., da.

CONTRIBUTORY (Secondary)

(Duration) *10* yrs., mos., da.

(Signed) *A. T. Rice* M. D.

*Jan 7, 1915* (Address) *24 S. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

*Oak Lawn Cemetery* *Jan 8, 1915*

*Albert C. Fuller* *220 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81709

31 C81709

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Ave* ST.; *18* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *114 Schroeder St* St.; yrs. mos. ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*Black*

## 5-SINGLE,

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*July 25*, 1887  
(Month) (Day) (Year)

## 7-AGE,

*27* yrs. *5* mos. *11* ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Cook*

## 9-BIRTHPLACE,

(State or Country),

*Maryland*

## 10-NAME OF FATHER,

*Blaise Snowden*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*MD*

## 12-MAIDEN NAME OF MOTHER

*Susan Johnson*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*MD*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. B. Curry*(Address) *114 Schroeder St*

## 15-

JAN 8 - 1915 ROBERT KRAUTER, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 5*, 1915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Oct 28* 1914 to *Jan 5* 1915that I saw him alive on *Jan 5* 1915and that death occurred, on the date stated above, at *12:15* p.m.

The CAUSE OF DEATH\* was as follows:

*Tuberculous peritonitis*(Duration) *Several* yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

*Fecal fistula* (Duration) *1* yrs. *1* mos. *1* ds.(Signed) *C. H. Wall*

M. D.

*Jan 5*, 1915 (Address) *114 Schroeder St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *38* ds. In the State *29* yrs. mos. ds.Where was disease contracted, if not at place of death? *Auspicious*Former or usual residence *114 Schroeder St*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Hubert* *Jan 8*, 1915

## 20-UNDERTAKER

## ADDRESS

*Alfred J. Farrell* *114 Schroeder St*

N. B.—Every item of information furnished on this certificate is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81710

119 REGISTERED NO. C81710

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1932 Frederick Rr.

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME Annie H. Metzler

(Residence in Baltimore: No. 1932 Frederick Rr.

St. 22 yrs. - mos. - ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 MARRIED Married (Write the word)

6 DATE OF BIRTH October 7, 1872 (Month) (Day) (Year)

7 AGE 42 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9 BIRTHPLACE (State or country) England

10 NAME OF FATHER Charles Flower

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Anna Ditta

13 BIRTHPLACE OF MOTHER (State or country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Metzler

(Address) 1932 Frederick Rr.

JAN 8 - 1915 ROBERT A. KRAUTER, Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 7, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1914, to Jan 7, 1915, that I saw her alive on Jan 7, 1915, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH\* was as follows:

Acute Bright's Disease

Contributory (SECONDARY) Nephritis (Duration) yrs. mos. ds.

(Signed) Harry Goldberg, M. D. (Address) 2031 W Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

1003 W Baltimore



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81711

# HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C81711

## CERTIFICATE OF DEATH

1 PLACE OF DEATH  
CITY OF BALTIMORE (No. 10440 N Fayette St. ST. 18 WARD)  
2 FULL NAME Susanne R. Kelley  
(Residence in Baltimore: No. 10440 N Fayette St. St. 30 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)  
6 DATE OF BIRTH June 13, 1857  
(Month) (Day) (Year)  
7 AGE 62 yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.?

### 8 OCCUPATION

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

### 9 BIRTHPLACE (State or country)

Howard Co Md

### 10 NAME OF FATHER

David McKinnie

### 11 BIRTHPLACE OF FATHER (State or country)

Howard Co Md

### 12 MAIDEN NAME OF MOTHER

Sarah Jones

### 13 BIRTHPLACE OF MOTHER (State or country)

Howard Co Md

### 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles H. Keller  
(Address) 10440 N Fayette St.

15

Filed

JAN 8 - 1915

ROBERT J. KRAUTER,  
Serial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 7, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Dec 3, 1914 to Jan 6, 1915, that I saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 1:10 m. The CAUSE OF DEATH\* was as follows:

Apoplexy, (Soft)  
Heart Disease

(Duration) yrs. — mos. 20 ds.  
Contributory (SECONDARY) Arterio Sclerosis  
(Duration) yrs. — mos. — ds.  
(Signed) John E. Brown M. D.  
Jan 8, 1915 (Address) 710 N. W. Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

### 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence?

### 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Park Jan 9, 1915  
20 UNDERTAKER Wm. J. Clark ADDRESS 1013 W. B. Ave

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81712

## 1-PLACE OF DEATH

## CERTIFICATE OF DEATH.

28

C81712

CITY OF BALTIMORE: (No. 1402 McCulloch

## 2-FULL NAME

Elizabeth Berger

ST.: 14 WARD)

Residence in Baltimore: No. 1402 McCulloch

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 80 yrs. - mos. 9 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

female

## 4-COLOR OR RACE,

white

## 5-SINGLE,

MARRIED, *Single*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Dec. 29, 1834  
(Month) (Day) (Year)

## 7-AGE,

80 yrs. - mos. 9 ds.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country),

Balt.

## 10-NAME OF FATHER,

Clement Berger

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Senerer

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant).

Mrs. Francis Gissel

(Address) 1402 McCulloch St.

## 15-

JAN 8 - 1915

ROBERT

KRAUTER,

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 7th, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1914, to Jan 7th, 1915, that I saw him alive on Jan. 7th, 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis  
for 8 mos. to my knowledge  
just how long  
unknown (Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)

old age (Duration) yrs. mos. ds.

(Signed) Heas Baltimore M. D.  
Jan. 7, 1915 (Address) 700 W. 1st St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL, OR REMOVAL,

New Cathedral

## DATE OF BURIAL,

Jan 9, 1915

## ADDRESS

1003 W. Baltimore

## 20-UNDERTAKER

J. B. Clark

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 C81713

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1222 Madison Ave St.; ..... yrs., ..... mos. ..... ds.)

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 1<sup>st</sup>*, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1914, to January 7 1915,  
that I saw ~~him~~ alive on Jan 7 1915,  
and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. .... mon. 4 ds

**CONTRIBUTORY**  
**(Secondary)**

..... (Duration) 8 hrs 15 min. ....

(Signed) James H. Hester H. D.  
Jan. 7, 1915. (Address) 1112 1/2 N. 1st St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
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Where was disease contracted,  
if not at place of death? .....

Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Littersville, G. G. Co. Md

Jan 8, 1915

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81714

## CERTIFICATE OF DEATH.

135 C81714

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. St. 10* WARD)2-FULL NAME *Hattie Rosenstem*(Residence in Baltimore: No. *914 E. Fayette* St.;yrs. *6* mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*married*

## 6-DATE OF BIRTH,

*Unknown*, 1 (Month) (Day) (Year)

## 7-AGE,

*34*

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

## 9-BIRTHPLACE, (State or Country),

*Russia*

## 10-NAME OF FATHER,

*Meyer Left*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Russia*

## 12-MAIDEN NAME OF MOTHER

*Schone Zimblech*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Russia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hosp*

## 15-

JAN 8 - 1915

ROBERT . KRAUTER,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*, 7, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 30, 1914*, to *Jan. 7, 1915*, that I saw her alive on *Jan. 7, 1915*, and that death occurred, on the date stated above, at *7.00 P m.*

The CAUSE OF DEATH\* was as follows:

*Puerperal Hemorrhage*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Uterine Infection*

(Duration) yrs. mos. ds.

(Signed) *T. D. Glass* M. D.*Jan. 8, 1915* (Address) *J. H. H.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 9 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *914 E. Fayette St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Hebrew Mt Carmel*

## DATE OF BURIAL,

*Jan. 8, 1915*

## 20-UNDERTAKER

*J. L. Loran + Co. Balt.*

## ADDRESS

*1107 E. Balto.*

N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIAN'S SIGNATURE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81715

## HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

28 C81715

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1212 N Chester

ST.

WARD)

2-FULL NAME

Anna Kling

Residence in Baltimore: No.

1212 N Chester

St. 25 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female White

4-COLOR OR RACE

MARRIED married  
(Write the word)

6-DATE OF BIRTH

Nov

1, 1889

(Month)

(Day)

(Year)

7-AGE

25

yrs.

2

mos.

5

ds.

or

min.?

If LESS than  
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

At home

9-BIRTHPLACE  
(State or country)

Baltimore

10-NAME OF FATHER

Philip Rittershyff

11-BIRTHPLACE OF FATHER  
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Sophia Beckner

13-BIRTHPLACE OF MOTHER  
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Kling

(Address) 1212 N Chester

## MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

January

6

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from  
Jan 20, 1915, to Jan 6, 1915,  
that I saw him alive on Jan 5, 1915,  
and that death occurred, on the date stated above, at 9:30 am.  
The CAUSE OF DEATH\* was as follows:

The CAUSE OF DEATH\* was as follows:

Tubercular  
(Duration) 9 yrs. mos. ds.Contributory  
(SECONDARY)(Signed) J. T. Kling  
Jan 7, 1915 (Address) 1212 N Chester

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

15-PLACE OF BURIAL OR REMOVAL

Oak Lawn Cem

UNDERTAKER

Herwig &amp; Co

DATE OF BURIAL

Jan 8

ADDRESS

2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 8 - 1915

ROBERT KRAUTER  
Supt. Permit Office  
REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81716

## CERTIFICATE OF DEATH.

79  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 N Lexington

ST. 19 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Sarah L. Hooper

(Residence in Baltimore: No. 1715 N Lexington

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

## 6-DATE OF BIRTH,

Sept 3rd, 1833

(Month)

(Day)

(Year)

## 7-AGE,

81 yrs. 4 mos. 3 da.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

New Jersey.

## 10-NAME OF FATHER,

Cornelius Van. Horn.

## 11-BIRTHPLACE OF FATHER

(State or Country),

New Jersey

## 12-MAIDEN NAME OF MOTHER

Catherine Scott

## 13-BIRTHPLACE OF MOTHER

(State or Country),

New Jersey

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs John Mc Coy

(Address)

1715 N Lexington St.

## 15-

ROBERT

KRAUTH

## 16-PLACE OF BURIAL OR REMOVAL,

Baltimore Md.

## DATE OF BURIAL.

1-9-1915

## 17-UNDERTAKER

E. B. Harle

## ADDRESS

115 E. West St.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 7th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915, to Jan 7, 1915, that I saw her alive on Jan 7, 1915, and that death occurred, on the date stated above, at 7:25 p.m.

The CAUSE OF DEATH\* was as follows:

Stenocardia or heart failure

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Harle M. D.

Jan 7, 1915 (Address) 115 E. West St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

JAN 8 - 1915

Serial Permit Clerk

Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081717 HEALTH DEPARTMENT—CITY OF BALTIMORE  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JAN 8 - 1915

Filed

ROBERT KRAUTER,  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed) M. D. Sage

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death  
Where was disease contracted,  
If not at place of death  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81718

C81718

## CERTIFICATE OF DEATH

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST.; *4th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and Out-pat. No. 18.)

2-FULL NAME *Mr. William R. Galbreath*

(Residence in Baltimore: No. *Delta, York Co. Pa.* St.; yrs., mos., ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH *October 12, 1850*  
(Month) (Day) (Year)

7-AGE *64 yrs. 2 mos. 26 ds.* If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *Farmer*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Near Dublin, Harford Co. Md.*

10-NAME OF FATHER *Alexander Galbreath*

11-BIRTHPLACE OF FATHER (State or Country) *Harford Co Md.*

12-MAIDEN NAME OF MOTHER *Catharine Ramsay*

13-BIRTHPLACE OF MOTHER (State or Country) *Delta, York Co. Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. F. Galbreath*

(Address) *Tarlington Md.*

15 JAN 8 - 1915 ROBERT KRAUTER, Registrar.

Surial Permit Clerk.

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 8, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I attended deceased from *Dec 24* 191*4*, to *Jan 8* 191*5*, that I saw him alive on *Jan 7* 191*5*, and that death occurred, on the date stated above, at *430 m.*

The CAUSE OF DEATH\* was as follows:  
*Pharyngitis*

(Duration) .... yrs. .... mos. *14 ds.*

CONTRIBUTORY (Secondary) *Peritonitis*

(Duration) .... yrs. .... mos. *8 ds.*

(Signed) *Edwin J. Davis* M. D.

191... (Address) .....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yes. .... mos. .... ds. To the State yes. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *State Hill Pa.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Jan. 11, 1915*

20-UNDERTAKER ADDRESS *17 S. Broadway*

*H. C. Hughes*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81719

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

28 C81719  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 William St.)

ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1412 William St.)

St.: yrs. / mos. 7 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Married

## 6-DATE OF BIRTH,

Jan. 15, 1881  
(Month) (Day) (Year)

## 7-AGE,

23 yrs. 1 mos. 21 ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac L. Singer

(Address) 1412 William St.

## 15-

Filed 5161 - 8 NAI 1915

JOHN

KRAUTER

Registration

Burial Per

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 6, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1915, to Jan. 6, 1915, that I saw him alive on Jan. 1, 1915, and that death occurred, on the date stated above, at 7:15 pm.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(Duration) 13 yrs. 1 mos. 21 ds.

## CONTRIBUTORY (Secondary)

(Duration) 7 yrs. 1 mos. 7 ds.

(Signed) M. D.

Jan. 7, 1915. (Address) 1412 William St.

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At Place of death 7 yrs. 1 mos. 7 ds.

Where was disease contracted, if not at place of death? Pleasantville Hf.

Former or usual residence Pleasantville Hf.

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL,

Landon Park Cem. Jan. 9, 1915.

## 20-UNDERTAKER

## ADDRESS

Mrs. J. H. Singer 1318 E. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81720

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Infant

6-DATE OF BIRTH,

Dec. 27, 1914  
(Month) (Day) (Year)

7-AGE,

yrs. 11 mos. 11 ds.

If LESS than 1 day,  
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

William Blakey

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Lucie Shirley

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Blakey

(Address) Woodlawn St. Md.

15-

5161 - 8 JAN

ROBERT KRAUTH,  
Bureau of Health  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan. 6, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1914, to Jan. 6, 1915, that I saw her alive on Jan. 6, 1915, and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH\* was as follows:

Congenital Syphilis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. L. M. D.

Jan. 6, 1915. (Address) Woodlawn St. Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Woodlawn St. Md.

19-PLACE OF BURIAL OR REMOVAL,

Union Cemetery

DATE OF BURIAL,

Jan. 9, 1915

20-UNDERTAKER

As Marshall

ADDRESS

3539 Falls

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81721

79 C81721

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1238 E Madison* ST. *10* WARD)2-FULL NAME *Mary A. Tier (Tier)*(Residence in Baltimore: No. *1238 E Madison* St. .... yrs., .... mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *widow*  
(Write the word.)6-DATE OF BIRTH, *Mar 20, 1837*

(Month)

(Day)

(Year)

7-AGE, *77 yrs. 9 mos. 18 ds.*

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Mr Marshall*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Tier*(Address) *1238 E Madison*

## 15-

Filed *JAN 8, 1915*

191

ROBERT KRAUTER,  
Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 8, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 20, 1914*, to *Jan 8, 1915*, that I saw her alive on *Jan 8, 1915*, and that death occurred, on the date stated above, at *8 a. m.*

The CAUSE OF DEATH\* was as follows:

*Organic Disease of Heart with Acute Sclerotic*  
(Duration) *3 yrs.* .... mos. .... ds.CONTRIBUTORY (Secondary) *Arterio Sclerosis*(Duration) *5 yrs.* .... mos. .... ds.(Signed) *William E. Burton* M. D.*Jan 8, 1915* (Address) *762 Dolphin*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Annapolis Md*DATE OF BURIAL, *Jan 10, 1915*20-UNDERTAKER *George Schilling & Sons*ADDRESS *1126 E Monument*

N. B. Every item of information furnished must be carefully checked for accuracy. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81722

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81722

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *115 W. Hill* ST.; *22* WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Susan Viola Gorman*(Residence in Baltimore: No. *115 W. Hill* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*Colored*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH.

*May 10, 1914*  
(Month) (Day) (Year)

## 7-AGE,

*8 mos. 27 ds.*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *home*

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country), *Balto.*

## PARENTS.

10-NAME OF FATHER, *Hessie Gorman*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Balvert Co. Ind.*12-MAIDEN NAME OF MOTHER *Rhea Offer*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Balvert Co Ind.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Hessie Gorman*(Address), *115 Hill St.*

## 15-

Filed

JAN 8 - 1915

ROBERT

KRAUTER,

16-SERIAL-*Permit to Burial*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 6, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 6, 1915, to Jan 6, 1915,*that I saw him alive on *Jan 6, 1915,*and that death occurred, on the date stated above, at *6:25 P. m.*

The CAUSE OF DEATH\* was as follows:

*difficult ventilation*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. G. Gorman* M. D.*Jan 7, 1915* (Address) *1704 Madison St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Auburn* *Jan 8, 1915*

## 20-UNDERTAKER

## ADDRESS

*H. L. Brown & Son 10 N. W. 10th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81723

## CERTIFICATE OF DEATH.

71 C81723  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Bond

## 2-FULL NAME

(Residence in Baltimore: No. 824 N. Bond

ST.: 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. 11 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

## 6-DATE OF BIRTH

Oct. 8, 1915

(Month)

(Day)

(Year)

## 7-AGE

3

28

da.

If LESS than 1 day.

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE.  
(State or Country),

Baltimore, Md.

## 10-NAME OF FATHER,

Seroy Stevens

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore, Md.

## 12-MAIDEN NAME OF MOTHER

Justine Bauman

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore, Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Mary Bauman

(Address)

824 N. Bond St.

## 15-

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan - 7, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1915, to Jan 7, 1915, that I saw him alive on Jan 7, 1915, and that death occurred, on the date stated above, at 3:30 P.M.  
The CAUSE OF DEATH\* was as follows:

Infantile Convulsion

(Duration) yrs. mos. 3, da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 2, da.

(Signed)

J. A. D. Smith M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer Cemetery

## DATE OF BURIAL

Jan 9, 1915

## 20-UNDERTAKER

Henry Horck Lee

## ADDRESS

134 E. Bay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 8 - 1915

ROBERT KRAUTER  
Barial Forall Clerk  
Registrar.

C81724

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3003 E. Baltimore* ST. *4* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *3003 E. Baltimore* St. *77* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, *Unmarried*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

*April 27*, 19*37*  
(Month) (Day) (Year)

## 7-AGE,

*77* yrs., *8* mos., *21* ds.  
If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired**Marine*9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. J. E. M. Cullough*  
(Address) *3003 E. Baltimore St.*

## 15-

Filed *8-13-15*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*June 5*, 19*15*  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 19*15*, to *June 5*, 19*15*, that I saw him alive on *Jan 1*, 19*15*, and that death occurred, on the date stated above, at *6:30* P.M.

The CAUSE OF DEATH\* was as follows:

*Senility*(Duration) *7* yrs., *1* mos., *1* ds.CONTRIBUTORY *chronic indigestion*  
(Secondary)(Duration) *1* yrs., *1* mos., *1* ds.(Signed) *J. H. Insley* M. D.*John H. Insley*, 191*5*, (Address) *2938 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *77* yrs., *8* mos., *21* ds. In the State *77* yrs., *8* mos., *21* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Arund Ridge*

## DATE OF BURIAL,

*7-9*, 19*15*

## 20-UNDERTAKER

*Wm Cook*

## ADDRESS

*Arund Ridge*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81725

C81725

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *115* *Poppleton* ST.: *18* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *105* *Poppleton* St.: *22* yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH, *unknown*, 1 (Month) (Day) (Year)

7-AGE, *60* yrs., mos., da. IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *none*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER, *James McKeown*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *J. J. Cowan & Son*  
(Address), *901 Hollins Street*

15-

STEN 8-1915 ROBERT K. KRAUTH  
JUL 12 1915 Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 7*, 191*5*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 3*, 191*5*, to *Jan 7*, 191*5*, that I saw her alive on *Jan 6*, 191*5*, and that death occurred, on the date stated above, at *6 a.* m.

The CAUSE OF DEATH\* was as follows:

*Pericardial Anemia*

CONTRIBUTORY (Secondary) *Exhaustion*

(Signed) *J. J. Cowan* M. D.

*Jan 7*, 191*5* (Address) *1733 Hollins St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery* DATE OF BURIAL, *Jan 11*, 191*5*

20-UNDERTAKER, *John Herman* ADDRESS, *901 Hollins St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.







## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81727

C81727

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1800 Poplar Grove (Walbrook)* St. yrs. mos. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*white*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH

*Jan* *21<sup>st</sup>*, *1893*  
(Month) (Day) (Year)

## 7-AGE,

*22*

yrs. mos. da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Stenographer*9-BIRTHPLACE,  
(State or Country).*Maryland*

## 10-NAME OF FATHER,

*John H Powers Sr*11-BIRTHPLACE OF FATHER  
(State or Country),*Ind*

## 12-MAIDEN NAME OF MOTHER

*Annie Reinhardt*13-BIRTHPLACE OF MOTHER  
(State or Country),*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs. Jessie Eney*

(Address)

*1800 Poplar Grove St*

## 15-

JAN 8 1915

ROBERT KRAUTER,  
Merial Mortuary Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*January 6, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Jan. 5, 1915* to *Jan. 6, 1915*,  
that I saw her alive on *Jan. 6, 1915*,  
and that death occurred, on the date stated above, at *4<sup>50</sup> a.m.*

The CAUSE OF DEATH\* was as follows:

*Epilepsy*(Duration) *3* yrs. mos. da.CONTRIBUTORY  
(Secondary)*Uremia*(Duration) *2* yrs. mos. da.(Signed) *M. B. Levine* M. D.191... (Address) *Hebrew Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* da. In the State *22* yrs. mos. da.Where was disease contracted, if not at place of death? *at home 1800 Poplar Grove*Former or usual residence *1800 Poplar Grove (Walbrook)*

## 19-PLACE OF BURIAL OR REMOVAL,

*Lorraine Cemetery*

## DATE OF BURIAL,

*Jan. 10, 1915*

## 20-UNDERTAKER

*Geo. A. Gerbig*

## ADDRESS

*Baltimore*

N. B.—Every item of information entered on Certificate supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81728

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business,

or establishment in which

employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JAN 9 - 1915

ROBERT J. KRAUTER

Marital Permit Officer

Filed....., 191.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 28 1914, to Jan 5 1915,

that I saw him alive on Jan 4 1915,

and that death occurred, on the date stated above, at 14 m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocardial Insufficiency

Chronic Nephritis (Secondary)

1 Known 2 mos.

(Duration) yrs. mos. ds.

CONTRIBUTORY Acute Suppression 36 hrs.

(Secondary) (Duration) yrs. mos. ds.

(Signed) G. Carroll Lockard M. D.

Jan 7, 1915. (Address) 4 E. Presler St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

JAN 9 - 1915

ADDRESS

6 S. Fitzpatrick St.

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81729

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81729

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ....)

2-FULL NAME

Residence in Baltimore: No. ....

REGISTERED NO. C. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 1 yrs. 9 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, .... hrs.,  
or .... min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

HARRY O. ADAMS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from Sept 14, 1914, to Jan 7, 1915, that I saw him alive on Jan 6, 1915, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH\* was as follows:

Sub  
acute septicemia

Contributory  
(SECONDARY)

(Signed) Edgar Friedenwald M. D.  
Jan 9, 1915 [Address] 1616 Linden Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSMIENTS, OR RECENT RESIDENTS]

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? before admission  
Former or usual residence St. Elizabeth's Home

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Ceme.

Jan 8, 1915

20-UNDERTAKER

ADDRESS

George Holland

517 Robert St.



C81730

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81730

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1614 Carlos terrace* St.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1614 Carlos terrace* St.; *—* yrs., *—* mos., *—* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH

*Unknown*, *1* (Month) (Day) (Year)

## 7-AGE

*46* yrs., *—* mos., *—* da.

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*House wife*

## 9-BIRTHPLACE, (State or Country),

*Virginia*

## 10-NAME OF FATHER,

*Adam Jones*

## 11-BIRTHPLACE OF FATHER (State or Country),

*va*

## 12-MAIDEN NAME OF MOTHER

*unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Wells*(Address) *1614 Carlos terrace*

## 15-

JAN 9 - 1915

HARRY O. ARDRETS,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*, *7*, *1915* (Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

*Oct 13* 1914, to *January* 1915.that I saw him alive on *Jan 6*, 1915.and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH\* was as follows:

*mitral and aortic**insufficiency**unknown* (Duration) *—* yrs., *—* mos., *—* da.

## CONTRIBUTORY

(Secondary)

*one month* (Duration) *—* yrs., *—* mos., *—* da.

(Signed)

*Edward J. Furber* M. D.*Jan 7*, 1915 (Address) *1614 Carlos terrace*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* da. In the State *—* yrs., *—* mos., *—* da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Mt. Auburn Cem.*

## DATE OF BURIAL,

*Jan 8*, 1915.

## 20-UNDERTAKER

*George H. Holland*

## ADDRESS

*3-17 Robert St.*

N. B.—Every item of information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81731

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81731

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. \_\_\_\_\_ ST. \_\_\_\_\_ WARD \_\_\_\_\_)

## REGISTERED NO. C \_\_\_\_\_

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. \_\_\_\_\_ St. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If write the word.)

Married

## 6-DATE OF BIRTH

- Unknown 1860 (Month) (Day) (Year)

## 7-AGE

34

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

Hot presser

## 9-BIRTHPLACE

(State or Country),

Balto

## 10-NAME OF FATHER

Adam Krans

## 11-BIRTHPLACE OF FATHER (State or Country)

Germany

## 12-MAIDEN NAME OF MOTHER

Don't know

## 13-BIRTHPLACE OF MOTHER (State or Country)

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Heise

(Address) 236 Patterson Park ave

## 15-

JAN 9 - 1915

HARRY O. ANDREWS,

Filed \_\_\_\_\_ 191... Serial Permitt. Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan 6, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 27 1914, to Jan 6 1915, that I saw him alive on Jan 6 1915, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH\* was as follows:

Intestinal Obstruction

## CONTRIBUTORY (Secondary)

flexure (Duration) yrs. mos. 3 ds. (Signed) Edward J. Johnson, M.D. Jan 6, 1915 (Address) 117 N. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 34 ds. In the State yrs. mos. 4

Where was disease contracted, if not at place of death? 600 Hanover St. City

Former or usual residence 600 Hanover St. City

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Holy Cross Jan 7, 1915

## 20-UNDERTAKER

## ADDRESS

J. A. Krause 763 Hanover

N. B.—Every item of information should be carefully supplied. AGE, MONTHS, AND DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81732

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81732

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 78 yrs. — mo. 12 da.

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,  
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 9 - 1915 HARRY O. ANDREWS,  
Filed Serial Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from  
Nov 24, 1914, to Jan 7, 1915,that I saw him alive on Jan 7, 1915,  
and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. All names should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

73  
C81733

CITY OF BALTIMORE: (No. *1214 W Lombard* ST.: *18* WARD)

2-FULL NAME *Ellen Dearing*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1214 W Lombard* St.: \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE  
MARRIED *Married*  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH *Jan 13 1889*

(Month)

*13*

(Day)

*1889*

(Year)

7-AGE *28*

yr.

*11*

mos.

*24*

ds.

or

min.?

If LESS than 1 day, \_\_\_\_\_ hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Housewife*

9-BIRTHPLACE (State or country)

*Balt Md*

PARENTS

10-NAME OF FATHER

*John Leonard*

11-BIRTHPLACE OF FATHER (State or country)

*Ireland*

12-MAIDEN NAME OF MOTHER

*Catharine Smith*

13-BIRTHPLACE OF MOTHER (State or country)

*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. Dearing*

(Address) *1214 W Lombard St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 6 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 1 1914*, to, *Jan 6 1915*,

that I saw her alive on *Jan 6 1915*,

and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Multiple Myeloma*

Contributory (SECONDARY)

*Chronic*

(Signed) *Jos E. Munn*

M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Augustine, Elbridge*

*Jan 28 1915*

20-UNDERTAKER

ADDRESS

*John J. Fields, 1100 N. Lombard St*

15-  
JAN 9 - 1915  
Filed

HARRY O. AEDERES,  
Serial Permit Clerk,  
REGISTRAR



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81734

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

C81734

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 932 S Sharp St

2-FULL NAME

None

(Residence in Baltimore: No. 932 S Sharp St

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Jan 8, 1915.  
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

Tony Gerage

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Jennie Lavanella

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tony Gerage

(Address) 932 S Sharp St

15-

JAN 9 - 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 8, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Premature Birth

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Jan 8, 1915 (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Peter Cemetery Jan 7, 1915.

20-UNDERTAKER

ADDRESS

Mr J E Evans 1425 N Charles St





## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1342 Stricker* ST.; *15* WARD)2-FULL NAME *Lloyd Norris*(Residence in Baltimore: No. *1342 N. Stricker* St.; *15* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, *widower*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

*Sept 17, 1860*  
(Month) (Day) (Year)

7-AGE,

*57* yrs., *3* mos., *20* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer), *Stone quarry*

9-BIRTHPLACE, (State or Country),

*Baltimore County Md*

10-NAME OF FATHER,

*William Norris*

11-BIRTHPLACE OF FATHER (State or Country),

*Baltimore County Md*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER (State or Country),

*Balt. County Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles E. Clark*(Address) *1377 N. Gilman*

15-

JAN 9 - 1915

Filed

HARRY O. ANDREWS

Berial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 7, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *November 30 1914*, to *January 7 1915*; that I saw him alive on *January 7 1915*, and that death occurred, on the date stated above, at *9:30 m.*

The CAUSE OF DEATH\* was as follows:

*Apoplexy*(Duration)....yrs. *1* mos. *7* ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs. ....mos. ....ds.

(Signed) *Charles E. Clark* M. D.*Jan. 7, 1915* (Address) *1377 N. Gilman*

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. ....mos. ....ds. In the State yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Hanover, Md**Dec. 19, 1914*

UNDERTAKER

*John A. Bishop*ADDRESS *1107**Other*

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81737

## CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; WARD) *4*

2-FULL NAME

(Residence in Baltimore: No. *Chas. Linenmeyer* St.; yrs. mos. ds.)  
*216 Commerce*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,  
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JAN 9 - 1915

Filed

191

HARRY O. ANDREWS,  
Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan. 8, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY. That I attended deceased from  
*Dec. 11, 1914* to *Jan. 8, 1915*  
that I saw him alive on *Jan. 8, 1915*  
and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*CONTRIBUTORY  
(Secondary)*Chronic Myocarditis*  
(Duration) yrs. mos. ds.(Signed) *James Newcomb, M.D.*  
*Jan. 8, 1915* (Address) *University Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? *Unknown*Former or usual residence *216 Commerce St.*

19-PLACE OF BURIAL OR CREMATION.

*Cathedral Cemetery*

20-UNDERTAKER

*Chas. J. Weaver Son 118 W. Mt. Royal Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81738

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81738

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *General Germanized Home*  
 CITY OF BALTIMORE: (No. *Baltimore* ST.; *70* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Julie Wagner*  
 (Residence in Baltimore: No. *Baltimore* ST. *unknown* yrs., *unknown* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-STATUS, *Widow*  
 (Write the word.)  
 6-DATE OF BIRTH, *Nov* *10*, *1840*  
 (Month) (Day) (Year)  
 7-AGE, *74* yrs. *1* mos. *29* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work... *None*  
 (b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), *Kurhessen Germany*

10-NAME OF FATHER, *George Commins*

11-BIRTHPLACE OF FATHER (State or Country), *Kurhessen Germany*

12-MAIDEN NAME OF MOTHER *Christine Ulrich*

13-BIRTHPLACE OF MOTHER (State or Country), *Kurhessen Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records of Germanized Home*  
 (Address) *Baltimore*

15-  
 JAN 9 - 1915

MARY O. ANDREWS,  
 Burial Permit Clerk  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan* *8*, *1915*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July* *1913*, to *Jan 8* *1915*, that I saw her alive on *Jan 7* *1915*, and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH\* was as follows:

*Exhaustion*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Paralysis*

(Duration) *1* yrs. *6* mos. ... ds.

(Signed) *F. N. Hobbins* M. D.

*Jan 8* *1915*. (Address) *1908 N. Balt St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs. *—* mos. *—* ds. In the State *unknown*

Where was disease contracted if not at place of death? *General Germanized Home*

Former or usual residence *General Germanized Home*

19-PLACE OF BURIAL OR REMOVAL, *London Park*

DATE OF BURIAL, *Jan 11*, *1915*

20-UNDERTAKER

ADDRESS *1503 N. Balt St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81739

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

28 C81739

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *522 Hoffman St.* ST.; *17* WARD)2-FULL NAME *Lewis Dixon*(Residence in Baltimore: No. *522 Hoffman St.* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*Cobd*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

## 6-DATE OF BIRTH,

*June*  
(Month)*1884*  
(Day) (Year)

## 7-AGE,

*30*yrs. *not known* mos. ds.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Waiter*

## 9-BIRTHPLACE, (State or Country).

*Easton Md*

## 10-NAME OF FATHER,

*not known*

## 11-BIRTHPLACE OF FATHER (State or Country),

*not known*

## 12-MAIDEN NAME OF MOTHER

*not known*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*not known*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clara Evans*(Address) *522 Hoffman St.*15-*JAN 9 - 1915*

Filed

191

ROBERT J. KRAUTER

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 8*

(Month)

(Day)

*1915*  
(Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 3rd* 1915, *only 1 visit - 1st*, that I saw him alive on *Jan 3rd* 1915, and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH\* was as follows:

*Tuberculosis**Don't know only seen him once*  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Exhaustion*

(Duration) yrs. mos. ds.

(Signed) *John J. Mangum* M. D.*Jan 8, 1915* (Address) *1202 Edmondson*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Aeburn*

## DATE OF BURIAL,

*1/9*, 1915

## UNDERTAKER

*Samuel J. Hensley 5700 Redick*

## ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81740

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 N. Carey ST.: 15 WARD)

### 2-FULL NAME

Mary Boyer

(Residence in Baltimore: No. 1348 N. Carey St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3-SEX

Female

#### 4-COLOR OR RACE

Col.

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

#### 6-DATE OF BIRTH

August 15, 1852  
(Month) (Day) (Year)

#### 7-AGE

62 yrs. 4 mos. 21 ds. or min.?  
If LESS than 1 day, hrs., min.?

#### 8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

#### 9-BIRTHPLACE (State or country)

Alexandria Va.

#### 10-NAME OF FATHER

Solomon Hodge

#### 11-BIRTHPLACE OF FATHER (State or country)

Alexandria Va.

#### 12-MAIDEN NAME OF MOTHER

Helena Johnson

#### 13-BIRTHPLACE OF MOTHER (State or country)

Alexandria Va.

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry L. Boyer

(Address)

1348 N. Carey St.

JAN 9 - 1915

Filed 191

ROBERT J. KRAUTER

Marital Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

#### 16-DATE OF DEATH

Jan 6, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24, 1914, to Jan 6, 1915.

that I saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH\* was as follows:

Dysentery, Cordic Fieber  
(Duration) yrs. mos. ds. 18

#### Contributory (SECONDARY)

(Signed) John H. W. Smith M.D.  
Jan 6, 1915 [Address] 1209 Presbman

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or present residence

#### 19-PLACE OF BURIAL OR REMOVAL

114 Auburn

#### DATE OF BURIAL

Jan 10, 1915

#### ADDRESS

578 N. Biddle

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81741

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4111 Reisterstown Road* St. *15* WARD)

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *4111 Reisterstown Road* St.; *2* yrs.,  mos.  ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)  
*Widow*

## 6-DATE OF BIRTH,

*May 21, 1823*  
(Month) (Day) (Year)

## 7-AGE,

*91 yrs. 5 mos. 16 ds.*If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired.*9-BIRTHPLACE,  
(State or Country),*Germany*

## 10-NAME OF FATHER,

*Backman*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Backman*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Schaefer*(Address) *4111 Reisterstown Road*

## 15-

*JAN 9 - 1915* *ROBERT . KRAUTER,*  
Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 7, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Dec 10, 1914*, to *Jan 7, 1915*,  
that I saw her alive on *Jan 6, 1915*,  
and that death occurred, on the date stated above, at *4.15 a.m.*

The CAUSE OF DEATH\* was as follows:

*Fraction of neck  
of femur  
Accidental fall over step*  
(Duration) *28* yrs. *28* mos. *28* ds.CONTRIBUTORY  
(Secondary)*Smile ability*(Duration) *28* yrs. *28* mos. *28* ds.(Signed) *James S. Ashbrook, M. D.**Jan 7, 1915* (Address) *4012 Park Heights av.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *28* yrs. *28* mos. *28* ds. In the State *28* yrs. *28* mos. *28* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Wesleyan Union*

## DATE OF BURIAL,

*Jan 10, 1915*

## 20-UNDERTAKER

*Daniel Easton*

## ADDRESS

*916 Penna av.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81742

## CERTIFICATE OF DEATH

8 C81742

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1111 Battery Ave.*

ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME *Edward Stitch*

(Residence in Baltimore: No. *1111 Battery Ave.*

St.: yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*  
(If write the word)

6 DATE OF BIRTH *June 29, 1914*  
(Month) (Day) (Year)

7 AGE *6* yrs. *11* mos. *11* ds. or min.?  
If LESS than 1 day, hrs.

### 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Child*

9 BIRTHPLACE (State or country)

*Balto. md.*

PARENTS

10 NAME OF FATHER

*Arthur J. Stitch*

11 BIRTHPLACE OF FATHER (State or country)

*Balto. md.*

12 MAIDEN NAME OF MOTHER

*Mary Annol*

13 BIRTHPLACE OF MOTHER (State or country)

*Balto. md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Mary J. Stitch*

(Address) *1111 Battery Ave.*

15 JAN 9 - 1915

ROBERT J. KRAUSE  
Burial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 8, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 8*, 1915, to *Jan 8*, 1915.

that I saw him alive on *Jan 8*, 1915, and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

*Personal knowledge 1 day 11 hours*  
(Duration) yrs. mos. *3* ds.

Contributory (SECONDARY)

*Measles Cough*  
(Duration) yrs. mos. ds.

(Signed)

*James B. Hall* M. D.  
*Jan 8*, 1915 (Address) *1203 Light*

\*State the DISEASE CAUSING DEATH, or, in deaths from Violent Causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*H. Patrick*

*Jan 9th, 1915*

20 UNDERTAKER

ADDRESS

*F. A. Krause*

*703 Hanover*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81743

C81743

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1823 Jackson*)ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1823 Jackson*)St.; *40* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*Unknown*

(Month) (Day) (Year)

7-AGE,

*67*

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ireland*

PARENTS.

10-NAME OF FATHER, *John Brady*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Ann Clark*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Daniel Brady*(Address) *1823 Jackson St.*

15-

JAN 9 - 1915 ROBERT KRAUTER, Registrar.

Filed..... 191

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 7, 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 1913* to *Jan 7 1915*that I saw him alive on *Jan 7 1915* and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Coronary Arteriosclerosis*

(Duration) yrs. mos. ds.

(Signed) *R. E. Campbell* M. D.*Jan 9, 1915* (Address) *1644 Jackson St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cemetery* *Jan 11, 1915*

20-UNDERTAKER

ADDRESS

*R. E. M. Flynn* *1422 Light St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81744

C81744

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 E Hamburg*ST. *24*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Richard Birrane*(Residence in Baltimore: No. *119 E Hamburg*St. *73* yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*male*

## 4-COLOR OR RACE.

*white*5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH.

*unknown*, *1842*  
(Month) (Day) (Year)

## 7-AGE.

*73*

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or  
kind of work. *Ship Carpenter*  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer)9-BIRTHPLACE,  
(State or Country),*Ireland*

## PARENTS.

10-NAME OF  
FATHER.*John Birrane*11-BIRTHPLACE  
OF FATHER  
(State or Country).*Ireland*12-MAIDEN NAME  
OF MOTHER*unknown*13-BIRTHPLACE  
OF MOTHER  
(State or Country).*unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Genie Birrane*(Address) *119 E. Hamburg St.*

## 15-

JAN 9 - 1915 ROBERT KRAUTER,  
Filed *191* Serial *Permit*

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 6, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*July 21, 1914, to Jan 6, 1915*that I saw him alive on *Jan 6, 1915*and that death occurred, on the date stated above, at *12 N*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Ticks*

(Location) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Endocarditis*

(Chronic) (Duration) yrs. mos. ds.

(Signed) *G. M. Flynn* M. D.*Jan 8, 1915* (Address) *301 E. Cross St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Western Cemetery*

## DATE OF BURIAL.

*Jan 11, 1915*

## 20-UNDERTAKER

*G. M. Flynn*

## ADDRESS.

*1422 Light St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81745 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

157  
C81745

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1619 HARLEM AVENUE,

ST. 16 WARD)

2-FULL NAME

BELLE E. TAYLOR,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 1619 HARLEM AVENUE.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

White,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single,

6-DATE OF BIRTH,

August 23d, 1882.

(Month)

(Day)

(Year)

7-AGE,

32 yrs. 4 mos. 15 ds.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Clerk in Dry goods store,

(b) General nature of industry, business, or establishment in which employed (or employer).

retired 3 years.

9-BIRTHPLACE,

(State or Country),

Maryland,

10-NAME OF FATHER,

Colin Taylor,

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland,

12-MAIDEN NAME OF MOTHER

Emma R. Chapman,

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel I. Thompson,

(Address)

1619 Harlem Avenue.

15-JAN 9 - 1915

JOSEPH T. KRAUTH

Serial Permit Clerk

Filed..... 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 7th, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, au-

topsy or inquiry.) and that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Strangulation with bath robe cord, suicide.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

(Coroner.)

Jan. 7th 1915 (Address)..... 1103 Valley st...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery

Jan 10 1915

UNDERTAKER

ADDRESS

W. S. Sweeney

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81746

## CERTIFICATE OF DEATH.

64 C81746

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *504 N. Fulton Ave* ST.: *20* WARD)FULL NAME *Jesse R. Thatcher*Residence in Baltimore: No. *504 N. Fulton Ave*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: ..... yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

6-DATE OF BIRTH.

*Oct 2<sup>nd</sup>*, 1830  
(Month) (Day) (Year)

7-AGE.

*84* yrs. *4* mos. *6* ds.

If LESS than 1 day,

.... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Caleb R. Thatcher*11-BIRTHPLACE OF FATHER  
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jesse R. Thatcher*(Address) *3907 Old York Rd*

15-

JAN 9 - 1915

ROBERT KRAUTER,

Filed..... 1915

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 8*, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec 27* 1914, to *Jan 8* 1915that I saw him alive on *Jan 8* 1915,and that death occurred, on the date stated above, at *3 a* m.

The CAUSE OF DEATH\* was as follows:

*Arterio-sclerosis*

(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) *S. M. Lymph* M. D.*Jan 2*, 1915 (Address) *626 N. Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Woodlawn Cemetery**Jan. 10, 1915*

20-UNDERTAKER

ADDRESS

*E. M. Whitehall**124 W. Fayette*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81747 HEALTH DEPARTMENT—CITY OF BALTIMORE

64081747

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1826 Gough St.* St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*May 13<sup>th</sup>, 1848*  
(Month) (Day) (Year)

7-AGE,

*66 yrs. 7 mos. 25 ds.*

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Salvage*

9-BIRTHPLACE,

(State or Country), *Md.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. P. Phelps*(Address) *Johns Hopkins*

15-

Filed

JAN 9 - 1915

ROBERT

Burial Permit

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 7, 1915*  
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from

*Jan 7, 1915*that I saw him alive on *Jan 7, 1915*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Epilepsy**3 hrs.*

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Frank A. Evans* M. D.*Jan 7, 1915* (Address) *Johns Hopkins*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1826 Gough St.*

19-PLACE OF BURIAL OR REMOVAL,

*Old Methodist*20-UNDERTAKER *Philip Herwig*DATE OF BURIAL *Jan 10, 1915*ADDRESS *2016 Orleans St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81748

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *622 S. Luzerne* St.; *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file cut No. 1B.)

2-FULL NAME

*Edward Ruczynski*

(Residence in Baltimore: No. *622 S. Luzerne St.* St.; ..... yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

*Single*

6-DATE OF BIRTH

*May*

*12, 1910*

(Month) (Day) (Year)

7-AGE

*4* yrs. *7* mos. *26* ds.

If LESS than  
1 day, ..... hrs.,  
or ..... min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*None*  
*Infant*

9-BIRTHPLACE  
(State or country)

*Balto City*

10-NAME OF FATHER

*Andrew Ruczynski*

11-BIRTHPLACE OF FATHER  
(State or country)

*Poland*

12-MAIDEN NAME OF MOTHER

*Alexandra Sumowski*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Jacob Fialkowski*

(Address)

*428 S. Bond St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan 8, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 5, 1915*, to, *Jan 8, 1915*, that I saw him alive on *Jan 7, 1915*, and that death occurred, on the date stated above, at *6 P.* m. The CAUSE OF DEATH\* was as follows:

*Typhoid fever*

Contributory  
(SECONDARY)

(Duration) ..... yrs. .... mos. *14* ds.

(Duration) ..... yrs. .... mos. *7* ds.

(Signed),

*A. L. Long* M. D.

*1/8, 1915* [Address] *2701 E. Baltimore*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE\* [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. .... mos. .... ds. In the ..... yrs. .... mos. .... ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Rosary Am Jan 9, 1915*

20-UNDERTAKER

ADDRESS

*Jacob Fialkowski 428 S. Bond St.*

JAN 9 - 1915

ROBERT KRAUTER,  
Burial Permit Clerk,  
REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81749

92 C81749

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *801 S. Streeper* ST.; *1* WARD)2-FULL NAME *Magdalena Schmeiser*(Residence in Baltimore: No. *801 S. Streeper* St. *58* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed* (Write the word.)6-DATE OF BIRTH, *Feb. 4<sup>th</sup>*, 183*6* (Month) (Day) (Year)7-AGE, *78* yrs., *11* mos., *2* ds. If LESS than 1 day, ....hrs. or ....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *None* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *John Hartz*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MA'DEN NAME OF MOTHER, *Not Known*13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Frank Schmeiser*(Address) *801 S. Streeper St.*15-*JOSEPH T. KRAUTER*

JAN 9 - 1915

Filed

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan*, *6*, 191*5*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 20* 191*4*, to *Jan 6* 191*5*,that I saw h alive on *Jan 6* 191*5*,and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*(Duration) .... yrs. .... mos. *10* ds.CONTRIBUTORY (Secondary) *Chancet*(Duration) .... yrs. .... mos. *6* ds.(Signed) *C. L. Long* M. D.17, 1915. (Address) *2701 Eastern ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Trinity Church*DATE OF BURIAL, *Jan 10*, 191*5*.20-UNDERTAKER, *H. Jander Sons*ADDRESS, *1710 Fleet St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81750

## CERTIFICATE OF DEATH.

REGISTERED NO. C

28 C81750

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 ST. Ward)

## 2-FULL NAME

(Residence in Baltimore: No. 423 Duin Hill Ave St.;        yrs.,        mos.,        ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE.

Black5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH.

       (Month) 1 (Day)        (Year)

## 7-AGE.

49 yrs.,        mos.,        ds.If LESS than 1 day,        hrs. or        min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work Labour.  
(b) General nature of industry, business, or establishment in which employed (or employer)       9-BIRTHPLACE.  
(State or Country),

## 10-NAME OF FATHER.

Do not know11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. P. L. Wright  
(Address) md Genl Hopkins

## 15-

JAN 9 - 1915 ROBERT L. KRAUTH,  
Filed Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Jan 5, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1915, to Jan 5, 1915, that I saw him alive on Jan 4, 1915, and that death occurred, on the date stated above, at 8.2 m.

The CAUSE OF DEATH\* was as follows:

Myocardial degeneration(Duration)        yrs.,        mos.,        ds.CONTRIBUTORY  
(Secondary)(Duration)        yrs.,        mos.,        ds.(Signed) Chas. L. Hopkins M. D.Jan 5, 1915 (Address) md Genl Hopkins

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death        yrs.,        mos.,        ds. In the State        yrs.,        mos.,        ds.

Where was disease contracted, if not at place of death?

Former or usual residence 423 Duin Hill Ave

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

JAN 8 - 1915

## 20-UNDERTAKER

Commissioner Health.

## ADDRESS

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 872 1/2 Lombard ST.; 3 WARD)FULL NAME Fannie E. Billmire(Residence in Baltimore: No. 872 1/2 W Lombard St.; . yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Dec 29, 1855  
(Month) (Day) (Year)7-AGE, 5-9 yrs. mos. ds. If LESS than 1 day, . hrs. or min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Baltic Md10-NAME OF FATHER, Wm H Cook11-BIRTHPLACE OF FATHER (State or Country), Baltic Md12-MAIDEN NAME OF MOTHER Mary A Kennolls13-BIRTHPLACE OF MOTHER (State or Country), Baltic Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Billmire(Address) 945 W Fayette St15-JAN 9 - 1915 JOHN T. KRAUTHFiled Jan 9 - 1915 JOHN T. KRAUTH Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov. 24th 1914, to Jan 7th 1915, that I saw her alive on Jan 7th 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH\* was as follows:

Acute Myocarditis(Duration) . yrs. 2 mos. 15 ds.CONTRIBUTORY (Secondary) Erythema Multiforme(Duration) . yrs. 3 mos. . ds.(Signed) J. H. Phillips M. D.Jan 7, 1915 (Address) 1701 Hollins St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Landon Park CemDATE OF BURIAL, Jan 15, 1915

20-UNDERTAKER

Robt Beebe & Son Co

ADDRESS

Calhoun & Hollis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PRINT, WITH ENVELOPE FOR THE HEALTH DEPARTMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81752

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

154 C81752  
REGISTERED NO. C

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *E Erdman Ave* ST. *8* WARD)

### 2-FULL NAME

*John Aichele*

(Residence in Baltimore: No. *E Erdman Ave* not numbered

St. *72* yrs. *7* mos. *27* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3-SEX

*Male*

#### 4-COLOR OR RACE

*White*

#### 5-SINGLE

*Married*

*Widowed*

*Or Divorced*

(Write the word)

*Widowed*

#### 6-DATE OF BIRTH

*August*

(Month)

*11*, *1842*

(Day)

(Year)

#### 7-AGE

*72*

yrs.

*4*

mos.

*27*

ds.

or

*min.*

hrs.

1 day,

hrs.

min.

If LESS than 1 day,

#### 8-OCCUPATION

(a) Trade, profession or particular kind of work

*Gardner*

(b) General nature of industry, business, or establishment in which employed (or employer)

#### 9-BIRTHPLACE

(State or country)

*Baltimore*

#### 10-NAME OF FATHER

*Joseph Aichele*

#### 11-BIRTHPLACE OF FATHER

(State or country)

*Germany*

#### 12-MAIDEN NAME OF MOTHER

*Regina Frank*

#### 13-BIRTHPLACE OF MOTHER

(State or country)

*Germany*

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs A. Aichele*

(Address)

*Erdman Ave*

### MEDICAL CERTIFICATE OF DEATH

#### 16-DATE OF DEATH

*January*

(Month)

*8*

(Day)

*1915*

(Year)

#### 17-I HEREBY CERTIFY, That I attended deceased from

*Jan 1*, 1915, to *Jan 8*, 1915,

that I saw him alive on *Jan 7*, 1915,

and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Insipientia of old age*

(Duration) *—* yrs. *—* mos. *—* ds.

#### Contributory (SECONDARY)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *Heppner* M. D.

*Jan 8*, 1915 [Address] *1618 Gough Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL

#### DATE OF BURIAL

*Old St Paul's Luth City* *Jan 10*, 1915

#### 20-UNDERTAKER

#### ADDRESS

*Mrs A Rohde* *730 Palmer*

JAN 9 - 1915

JOSEPH A. KRAUTER,

Serial Permit Clerk,  
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081753

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

120 081753

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 636 S. Decker Ave ST. 1

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Rose Hicks

(Residence in Baltimore: No. 636 S. Decker Ave

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Feb 3, 1884

7-AGE

30

11

4

If LESS than 1 day, hrs., or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

W. Va.

10-NAME OF FATHER

Peter McAlisbey

11-BIRTHPLACE OF FATHER (State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Kate Decker

13-BIRTHPLACE OF MOTHER (State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Hicks

(Address)

636 S. Decker Ave

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 7, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1915, to, Jan 6, 1915,

that I saw him alive on Jan 6, 1915,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Bright's

Contributory (SECONDARY)

Cardiac Hypertrophy

(Signed)

1/7

1915

[Address]

2701 Collins

a

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Rego Cathedral

DATE OF BURIAL

Jan 11th 1915

20-UNDERTAKER

John A. Moran

ADDRESS

Bank & Ann St.

JAN 9 - 1915

Filed

ROBERT KRAUTH  
Serial Permit Clerk  
REGISTRAR



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81754

66

C81754

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *713 W 33rd* ST. *13* WARD)

FULL NAME *Elizabeth Pyle*

(Residence in Baltimore: No. *713 W 33rd* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

1. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*  
(Write the word)

6. DATE OF BIRTH *Oct 29, 1829*  
(Month) (Day) (Year)

7. AGE *85* yrs. *2* mos. *9* ds. If LESS than 1 day, .... hrs. or .... min.?

8. OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) *None*

9. BIRTHPLACE (State or country) *Md*

10. NAME OF FATHER *Thomas McPhee*

11. BIRTHPLACE OF FATHER (State or country) *Don't know*

12. MAIDEN NAME OF MOTHER *Rebecca Hutchinson*

13. BIRTHPLACE OF MOTHER (State or country) *Don't know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Miss Mary U. Pyle*  
(Address) *713 W 33rd St.*

15. **JAN 9 - 1915** **ROBERT . KRAUTER,**  
Filed, 191. **Serial Permit Clerk**  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 7, 1915*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 27th*, 1914, to *Jan 7th*, 1915, that I saw her alive on *Jan 7th*, 1915, and that death occurred, on the date stated above, at *9* o'clock m. The CAUSE OF DEATH\* was as follows:

*Infirmities of age*  
*followed by Paralysis*  
(Duration) yrs. mos. ds.  
Contributory (SECONDARY) *Paralysis of right side*  
(Duration) yrs. mos. ds. *24 hrs*  
(Signed), *J. H. McPhee*, M. D.  
*Jan 9, 1915* (Address) *21 W 20th St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Linden Park Cem* DATE OF BURIAL *Jan 10, 1915*  
20. UNDERTAKER *Chas. E. French* ADDRESS *802 Madison Ave*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81755

64 C81755

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

706 Hayward Ave

ST.:

10

WARD)

REGISTERED NO. C

## 2-FULL NAME

Emma Green

(Residence in Baltimore: No.

706 Hayward Ave

St.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

female

## 4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)  
Married

## 6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

## 7-AGE

60

yrs., mos., ds.

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE

(State or Country),

Md

## 10-NAME OF FATHER

John Williams

## 11-BIRTHPLACE OF FATHER (State or Country),

Md

## 12-MAIDEN NAME OF MOTHER

Mary Johnson

## 13-BIRTHPLACE OF MOTHER (State or Country),

Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter Green

(Address)

706 Hayward St

## 15-

JAN 10 1915

ROBERT

KRAUTH

Filed

Serial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan

(Month)

7

(Day)

1915

(Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

Jan 3 1914, to Jan 7 1915

that I saw him alive on Jan 6 1915

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

paralysis  
apoplexy of heart

(Duration) yrs. mos. ds.

3 ds.

CONTRIBUTORY (Secondary)

Heart

(Duration) yrs. mos. ds.

3 ds.

(Signed) J. W. Green

Jan 7, 1915 (Address) 706 Hayward St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

Daniel Green

## DATE OF BURIAL

Jan 10, 1915

## 20-UNDERTAKER

Charles B. Jones

## ADDRESS

504 Rogers

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81756

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1605 E. Baltimore

ST.:

WARD)

## 2-FULL NAME

William Lipnick

(Residence in Baltimore: No.

1605 E. Baltimore

St.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., 10 mos. 11 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

## 6-DATE OF BIRTH,

Feb

27

1914

(Month)

(Day)

(Year)

## 7-AGE,

yrs. 10

mos. 11

ds.

10 LESS than 1 day,

... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE,

(State or Country),

Balto Md.

## 10-NAME OF FATHER,

Thomas Lipnick

## 11-BIRTHPLACE OF FATHER (State or Country),

Balto Md.

## 12-MAIDEN NAME OF MOTHER

Jessie Kianovsky

## 13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JAN 10 1915

ROBERT

KRAUTH

Filed.....

101

Burial Permit Clerk

20-UNDERTAKER

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ashes Mt Carmel

Jan 16 1915

JACK LEWIS

ADDRESS

1419 E. Baltimore

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan

9

1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec 10

1914

to

Jan 9

1915

that I saw her alive on

Jan 9

1915

and that death occurred, on the date stated above, at 11<sup>24</sup> m.

The CAUSE OF DEATH\* was as follows:

Lobar pneumonia

## CONTRIBUTORY (Secondary)

(Duration) yrs. 29 mos. 29 ds.

Heart in flames

(Duration) yrs. 10 mos. 10 ds.

(Signed) E. J. O'Sullivan M. D.

Jan 9, 1915 (Address) 24 N. Fulton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In this State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Ashes Mt Carmel

Jan 16 1915

JACK LEWIS

ADDRESS

1419 E. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81757

C81757

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2303 Garrison Ave* ST. *15* WARD) *64*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lucinda Smith*(Residence in Baltimore: No. *2303 Garrison Ave* St. yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow*  
(Write the word.)6-DATE OF BIRTH, *Oct 2, 1835*

(Month)

(Day)

(Year)

7-AGE, *79 yrs. 3 mos. 8 ds.*

If LESS than 1 day.

...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *W. Va*10-NAME OF FATHER, *Levi Smith*11-BIRTHPLACE OF FATHER (State or Country), *Va*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John W. Smith*(Address) *2303 Garrison Ave.*

## 15-

Filed

191

ROBERT E. TRAUBER

SPECIAL PUBLIC CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 10, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec. 18, 1914* to *Jan. 10, 1915*, that I saw her alive on *Jan. 9, 1915*, and that death occurred, on the date stated above, at *12:30* a.m. The CAUSE OF DEATH\* was as follows:*Cerebral Hemorrhage*

(Duration)

yrs.

mos.

*23* ds.

## CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) *W. H. Hoffman* M. D.*Jan 10, 1915*(Address) *1510 W. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Elkins W. Va*DATE OF BURIAL, *Jan. 10, 1915*UNDERTAKER *Harry W. Elkins*ADDRESS *1922*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *535 W. Hoffman St.*)

WARD

## 2. FULL NAME

(Residence in Baltimore: No. *535 W. Hoffman St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3. SEX.

*Male*

## 4. COLOR OR RACE,

*Col*

## 5. SINGLE,

*Widow*  
MARRIED,  
WIDOW,  
OR DIVORCED.  
(Write the word.)

## 6. DATE OF BIRTH,

*1857*  
(Month) (Day) (Year)

## 7. AGE,

*57*  
yrs. mos. da.

If LESS than 1 day.

hrs. or min.

## 8. OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE,  
(State or Country),

## 10. NAME OF FATHER,

11. BIRTHPLACE OF FATHER  
(State or Country),

## 12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER  
(State or Country),

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

## 15.

Filed

COMMISSIONER OF HEALTH

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH,

(Month)

(Day)

(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*1/3* 191*5*, to *1/4* 191*5*,that I saw him alive on *1/4* 191*5*,and that death occurred, on the date stated above, at *7 PM*.

The CAUSE OF DEATH\* was as follows:

*Pneumonia Embolism*  
(Duration) *14* yrs. *14* mos. *14* da.CONTRIBUTORY  
(Secondary)(Signed) *A. L. Elliott* M. D.

101... (Address)...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Belair Mt**Jan 10, 1915*

## 20. UNDERTAKER

## ADDRESS

*Robt A Elliott 506 East St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## C81759 HEALTH DEPARTMENT—CITY OF BALTIMORE

C81759

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2300 Harford Ave.* ST. *9* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *2300 Harford Ave.* St.: yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-~~status~~ MARRIED, *married*  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH.

*Nov 10<sup>th</sup>*, *1872*  
(Month) (Day) (Year)

## 7-AGE,

*42*

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Saloon Keeper*9-BIRTHPLACE,  
(State or Country),*Baltimore Md.*

## 10-NAME OF FATHER,

*Adam Bohmet*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Katherine Mayer*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Lena Bohmet*(Address) *2300 Harford Ave.*

## 15-

*JAN 10 1915*

Filed

ROBERT KRAUTH

Baltimore Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 6<sup>th</sup>*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Oct 23*, 191*4*, to *Jan 6*, 191*5*.that I saw him alive on *Jan 6<sup>th</sup>*, 191*5*, and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH\* was as follows:

*Septic Pneumonia*(Duration) yrs. *2* mos. *13* ds.CONTRIBUTORY (Secondary) *Subacute hemorrhage*

(Duration) yrs. mos. ds.

(Signed) *August Harry* M. D.*Jan 9*, 191*5* (Address) *44 E. 25th St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Western Cem.*

## DATE OF BURIAL,

*Jan. 10<sup>th</sup> 1915*

## ADDRESS

*1735 Harford Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81760

## CERTIFICATE OF DEATH.

+113 C81760

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.; *9* WARD)

### 2-FULL NAME

(Residence in Baltimore: No. *3313 Miller St.* St.; *11* yrs., *1* mos., *1* ds)

### REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *April 2, 1877* (Month) (Day) (Year)

7-AGE, *37* yrs., *9* mos., *4* da. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Engineer* (b) General nature of industry, business, or establishment in which employed (or employer), *Penn. R.R.*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Fredrick Tausendachon* 11-BIRTHPLACE OF FATHER, (State or Country), *Germany* 12-MAIDEN NAME OF MOTHER, *Margdalena Tausen,* 13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Augusta E Tausendachon* (Address), *3313 Miller St.*

15-

File

JAN 10 1915

ROBERT KRAUTH,

Funeral Permit Clerk

Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 6, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 27 1914* to *Jan 6 1915*, that I saw him alive on *Jan 6 1915*, and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH\* was as follows:

*Leinosis of Liver* (Duration) *3* yrs., *1* mos., *1* da.

CONTRIBUTORY (Secondary) *Myocarditis*

(Signed) *W. H. Warner* M. D. *Jan 6, 1915* (Address) *St Josephs Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *10* da. State yrs. mos. ds.

Where was disease contracted, if not at place of death? *3313 Miller St.*

Former or usual residence *3313 Miller St.*

19-PLACE OF BURIAL OR REMOVAL,

*Clear Lawn Cem.*

DATE OF BURIAL,

*Jan. 10, 1915*

20-UNDERTAKER

*Lilly & Ziehl*

ADDRESS

*403 S. Wolcott*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81761

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

91 C81761

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

539 W Hoffman

ST.

17

WARD)

2-FULL NAME

Martha Wright

(Residence in Baltimore: No.

539 W Hoffman

Sr.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Jan 8, 1913

(Month) (Day) (Year)

7-AGE

21

yrs.

mos.

ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balto

PARENTS

10-NAME OF FATHER

Arthur Wright

11-BIRTHPLACE OF FATHER (State or country)

md

12-MAIDEN NAME OF MOTHER

Alice Keller

13-BIRTHPLACE OF MOTHER (State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Wright

(Address)

539 W Hoffman

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 9, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

Dec. 27, 1914

to

Jan 9, 1915

that I saw her alive on

Jan 8, 1915

and that death occurred, on the date stated above, at

4 A m.

The CAUSE OF DEATH\* was as follows:

Pneumo pneumonia

Contributory (SECONDARY)

Pneumo pneumonia

(Signed)

Edw V. Schepers

M. D.

1/10/15, 1915

(Address)

1118 Drury Hill Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Johns Maryland

DATE OF BURIAL

1/11, 1915

20-UNDERTAKER

Sam'l. J. Hensley

ADDRESS

578 W Biddle

JAN 10 1915

Filed

ROBERT KRAUTER,

Serial Permit Clerk.

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

081762

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (Not in Baltimore: No. \_\_\_\_\_ ST.: \_\_\_\_\_ WARD) 7

## 2-FULL NAME

(Residence in Baltimore: No. \_\_\_\_\_ St.: \_\_\_\_\_ yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH

Oct 14, 1871  
(Month) (Day) (Year)

## 7-AGE

43

If LESS than 1 day,

....hrs. or....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

## 9-BIRTHPLACE, (State or Country),

Maryland

## 10-NAME OF FATHER,

James C. Dougherty

## 11-BIRTHPLACE OF FATHER (State or Country),

Charlottesville, Va.

## 12-MAIDEN NAME OF MOTHER

Louisa Lockley

## 13-BIRTHPLACE OF MOTHER (State or Country),

Voxester Co.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JAN 10 1915

ROBERT KRAUTH,

Filed..... 191... Serial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 9, 1915  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec 29 1914, Jan 9 1915,

that I saw her alive on Jan 4 1915,

and that death occurred, on the date stated above, at 7.55 p.m.

## The CAUSE OF DEATH\* was as follows:

Dural endochelonia  
Brain tumor  
C. C. Hospital, Baltimore  
(Duration) yrs. mos. da.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

## (Signed)

W. G. D. M. D.  
Jan 10 1915. (Address) J. H. Hoop

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11 da. In the State 43 yrs. mos. da.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Milford Ave. Howard Park

## 19-PLACE OF BURIAL OR REMOVAL,

Maryland Ave

## DATE OF BURIAL,

Jan 11, 1915

## 20-UNDERTAKER

Robert J. Turner

## ADDRESS

1111 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81763

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3021 York Road* ST.: *9* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *3021 York Road* St.: ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *Widow*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Don't know*  
(Month) ..... (Day) ..... (Year) .....

## 7-AGE,

*About 63*  
..... yrs. .... mos. .... ds.If LESS than 1 day,  
..... hrs. or ..... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).*At Home*9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant), *Lillian Knight*(Address) *1336 N. Washington*

15-JAN 10 1915

ROBERT KRAUTER,

Filed..... 191..... Permit Clerk.

Registrar.

## CERTIFICATE OF DEATH.

79 C81763  
REGISTERED NO. C(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number and  
fill out No. 18.)

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from  
*Oct. 10, 1914*, to *Jan. 8, 1915*,  
that I saw her alive on *Jan. 8, 1915*,  
and that death occurred, on the date stated above, at *109* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*(Duration) *2* yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)(Duration) *2* yrs. .... mos. .... ds.(Signed) *Rough Sorsy* M. D.*Jan. 10, 1915* (Address) *424 E. North Ave.*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

*St. Johns York Road* *Jan. 11, 1915*  
*William Cook* *1507 E. North Ave.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *930 N. Fayette* ST. *18* WARD)

REGISTERED NO. C

2-FULL NAME *Edgar H. Tyler*(Residence in Baltimore: No. *930 N. Fayette* St.; *3* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

*April 10*, 1883  
(Month) (Day) (Year)

7-AGE

*31* yrs. *9* mos. ds.If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Secretary*(b) General nature of industry, business, or establishment in which employed (or employer) *Tyler Can Co*9-BIRTHPLACE, (State or Country), *Mo*10-NAME OF FATHER *Geo M & Tyler*11-BIRTHPLACE OF FATHER (State or Country) *unknown*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Mo*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs E. F. Tyler*(Address) *930 Fayette St*15-*JAN 10 1915*

ROBERT K. KRAUTH

Filed..... 191

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 10*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 1st* 1915, to *Jan 10* 1915, that I saw him alive on *Jan 9* 1915, and that death occurred, on the date stated above, at *12:45* m.

The CAUSE OF DEATH\* was as follows:

*Chronic Anemia*(Duration)..... yrs. .... mos. *3* ds.CONTRIBUTORY (Secondary) *Nephritis*(Duration)..... yrs. .... mos. *10* ds.(Signed) *Edward J. ...* M. D...... 1915. (Address) *930 N. Fayette St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn Cem*DATE OF BURIAL, *Jan 13*, 191520-UNDERTAKER *Jm Cook*ADDRESS *101 N. ...*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1029 Somerset St.* ST. *10* WARD)

FULL NAME

(Residence in Baltimore: No. *1029 Somerset St.* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 10 1915

Filed

DEPT. OF HEALTH,  
Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

I HEREBY CERTIFY, That I attended deceased from *December 20 1914*, to *January 8 1915*, that I saw him alive on *January 7 1915*, and that death occurred, on the date stated above, at *10 p. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081766

HEALTH DEPARTMENT—CITY OF BALTIMORE

081766

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *212 S. Washington* ST. *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Mary Brooke*

(Residence in Baltimore: No. *212 S. Washington* St.; *62* yrs. *62* mos. *62* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-MARRIED

*Married*

*Married*

*Married*

*Married*

*Married*

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*Married*

6-DATE OF BIRTH

*Oct*

*15, 1852*

7-AGE

*62* yrs. *2* mos. *23* ds.

If LESS than 1 day, hrs., or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*at home*

9-BIRTHPLACE

(State or country)

*Baltimore*

10-NAME OF FATHER

*Paul*

11-BIRTHPLACE OF FATHER  
(State or country)

*Germany*

12-MAIDEN NAME OF MOTHER

*Don't know*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Miss Mollie H. Cassner*

(Address)

*212 S. Washington*

JAN 10 1915

ROBERT . KRAUTER,  
Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan*

*8*

*1915*

I HEREBY CERTIFY, That I attended deceased from *Dec 19, 1914*, to, *Jan 8, 1915*, that I saw her alive on *Jan 8, 1915*, and that death occurred, on the date stated above, at *7 a.m.*

The CAUSE OF DEATH\* was as follows:

*La Grippe*

Contributory (SECONDARY)

*Lobar Pneumonia*

(Signed)

*Geo. Heller*

*Jan 9, 1915* [Address] *1937 Gough St.*

\* State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Baltimore Cem*

DATE OF BURIAL

*Jan 11, 1915*

20-UNDERTAKER

*Herrig & Co*

ADDRESS

*2008 Orleans*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81767

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *815 N. Arlington ave* ST. *16* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *815 N. Arlington ave* ST. *16* yrs. *64* mos. *18* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

## 6-DATE OF BIRTH

*20 day of July*, 1850  
(Month) (Day) (Year)

## 7-AGE

*64* yrs. *5* mos. *18* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

## 9-BIRTHPLACE.

(State or Country), *Baltimore*

## PARENTS.

## 10-NAME OF FATHER

*Herman v. Hagel*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Holland*

## 12-MAIDEN NAME OF MOTHER

*Catherine Westendorp*

## 12-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas. Deuper*(Address) *815 N. Arlington ave*

JAN 10 1915

Filed

ROBERT

KRAUTH

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*July*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov. 6* 1914, to *Jan. 7* 1915, that I saw her alive on *Jan. 7* 1915, and that death occurred, on the date stated above, at *4:30* p.m.

The CAUSE OF DEATH\* was as follows:

*arteriosclerosis*  
*& cerebral hemorrhage*  
(Duration) *3* yrs. *3* mos. *18* ds.

## CONTRIBUTORY (Secondary)

(Duration) *20* yrs. *10* mos. *20* ds.(Signed) *J. T. Mearns* M. D.*Jan. 9*, 1915. (Address) *108 E. Edwards*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *3* mos. *18* ds. In the State *1* yrs. *3* mos. *18* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Epiphany Cemetery*, *Jan 11*, 1915

## 20-UNDERTAKER

## ADDRESS

*Chas. J. Evans & Son*, *118 W. Mt. Royal Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81768

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81768

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2437 E. Monument* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2437 E. Monument* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

*Married*

## 6-DATE OF BIRTH

*Aug 31**1857*

(Month)

(Day)

(Year)

## 7-AGE

*57* yrs. *4* mos. *9* ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home work*9-BIRTHPLACE,  
(State or Country),*Md*

## 10-NAME OF FATHER,

*Adam Gruber*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Margaret Dahler*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nicholas Seifert*(Address) *2437 E. Monument St.*

## 15-

JAN 11 1915

HARRY O. ANDREWS

Filed Serial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 9**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec 15* 1914, to *Jan 9* 1915,that I saw her alive on *Jan 8* 1915,and that death occurred, on the date stated above, at *7:50 a* m.

The CAUSE OF DEATH\* was as follows:

*Diabetes and**Gangrene of toe*

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)*Exhaustion*

(Duration)

yrs.

mos.

ds.

(Signed) *Adolph C. Eisenberg* M. D.*Jan 10*, 1915. (Address) *201 N. Light St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Holy Redeemer Cemetery Jan 12*, 1915.

## 20-UNDERTAKER

## ADDRESS

*Christian Miller 2334 Jefferson St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 S Spring ST. 3 WARD)

2-FULL NAME

(Residence in Baltimore: No. 244 S. Spring St.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Esther Black  
(Address) 244 S Spring St.

15-JAN 11 1915

Filed... 1915. Burial Permit... HARRY O. ANDREWS, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from Jan 4 1915, to Jan 7 1915, that I saw her alive on Jan 7 1915, and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary) Apoplexy

(Signed) Nathan R. Bell, M. D.  
Jan 10, 1915 (Address) 234 S. Spring St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence 244 S Spring St.

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL

ADDRESS



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81770

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81770

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1368 Fremont Ave. St. 15)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Fowler

(Residence in Baltimore: No. 1368 Fremont Ave. St.; 4 yrs.  mos.  ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Widow

6-DATE OF BIRTH

November

(Month) (Day) (Year)

7-AGE

82

yr. mos. ds. or min.?

If LESS than  
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE  
(State or country)

Brunswick Co. Va.

10-NAME OF FATHER

Wm. Hill

11-BIRTHPLACE OF FATHER  
(State or country)

Va

12-MAIDEN NAME OF MOTHER

Louisa Johnson

13-BIRTHPLACE OF MOTHER  
(State or country)

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Fowler Daughter

(Address) 1368 Fremont Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan

9

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1914, to, Jan 9, 1915,

that I saw her alive on Jan 7, 1915,

and that death occurred, on the date stated above, at 4:05 p.m.

The CAUSE OF DEATH\* was as follows:

Acute nephritis

(Duration) yrs. 6 mos.  ds.

Contributory (SECONDARY) Cardiac Asthenia

(Duration) yrs. 10 mos.  ds.

(Signed) E. Williams Fry M.D.

Jan 9, 1915. [Address] 1928 Penna Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSCIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL

Mt Auburn Cem.

DATE OF BURIAL

Jan 12, 1915

20-UNDERTAKER

Wm J Johnson

ADDRESS

756 Baker St.

AN 11 1915

HARRY C. ALLEN, JR.

Burial Permit Clerk

REGISTRAR



C81771

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81771

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *8* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Hazel Norfolk*(Residence in Baltimore: No. *1627 Patterson Park ave.* St.; .....yra, .....mos, .....da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH

*Oct. 26, 1896*  
(Month) (Day) (Year)

## 7-AGE

*18 yrs. 2 mos. 18 da.*

If LESS than 1 day,

....hrs. or ....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Embroider*

## 9-BIRTHPLACE, (State or Country),

*Baltimore*

## 10-NAME OF FATHER,

*Wesley Norfolk*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Baltimore*

## 12-MAIDEN NAME OF MOTHER

*Fannie Fox*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Frederick Co.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fannie Norfolk*(Address) *1627 N. Patterson Park ave.*

## 15-

JAN 11 1915 HARRY O. ARDRETS,  
Filed..... 191... Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 9, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 8* 191*5*, to *Jan 9* 191*5*, that I saw her alive on *Jan 9* 191*5*, and that death occurred, on the date stated above, at *9:22* m.

The CAUSE OF DEATH\* was as follows:

*Typhoid Fever*

(Duration).....yrs.....mos.....da.

## CONTRIBUTORY (Secondary)

*Bilateral pneumonia*

(Duration).....yrs.....mos.....da.

(Signed) *Chas C. Arnes* M. D......, 191... (Address) *Med. Gen. Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence *1627 Patterson Pk. ave.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Cemetery*

## DATE OF BURIAL,

*Jan. 12, 1915*

## 20-UNDERTAKER

*Henry Lutz*

## ADDRESS

*1007 N Bond St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81772

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1601 Madison Ave*)

## 2-FULL NAME

Residence in Baltimore: No. *1601 Madison Ave*89  
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *60* yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

*Widow*

6-DATE OF BIRTH,

*May 5<sup>th</sup>, 1834*

7-AGE,

*80 yrs., 8 mos., 4 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Home*

9-BIRTHPLACE, (State or Country),

*Germany*

10-NAME OF FATHER,

*Solomon Hess*

11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Hinka Frank*

13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Blum*(Address) *1601 Madison Ave*15-  
JAN 11 1915

Filed

HARRY O. ANDREWS,

Baptist Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 9<sup>th</sup>, 1915*17- I HEREBY CERTIFY, That I attended deceased from *Jan 2* 1915, to *Jan 9* 1915, that I saw her alive on *Jan 8* 1915, and that death occurred, on the date stated above, at *2:15 A.M.*

The CAUSE OF DEATH\* was as follows:

*General Arterio-sclerosis*(Duration) *10* yrs. mos. ds.CONTRIBUTORY (Secondary) *15, pneumonia*(Duration) *16* yrs. mos. ds.(Signed) *Sylvanus B. Lings* M. D.*Jan 9* 1915. (Address) *1134 Linden St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In this State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Abel Solomon*

DATE OF BURIAL,

*Jan. 11, 1915*

20-UNDERTAKER

*David Soudheim*

ADDRESS

*1180 N. Broadway*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C81773

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81773

### 1-PLACE OF DEATH

CITY OF BALTIMORE, No. *Church Homes Bldg.* ST. *6*

REGISTERED NO. C

### 2-FULL NAME

*Mrs. Rebecca Swift*  
(Residence in Baltimore: No. *Roguel Heights*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. — yrs. — mos. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX,

*Female*

#### 4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
*Married*

#### 6-DATE OF BIRTH,

*May 16 1887*  
(Month) (Day) (Year)

#### 7-AGE,

*27 11 7*  
yrs. mon. ds.

If LESS than 1 day, ....hrs. or....min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer). *House Wife*

#### 9-BIRTHPLACE, (State or Country),

*Ill. U.S.A.*

#### PARENTS.

##### 10-NAME OF FATHER,

*James Houston*

##### 11-BIRTHPLACE OF FATHER (State or Country),

*Md.*

##### 12-MAIDEN NAME OF MOTHER

*Maud Woodruff*

##### 13-BIRTHPLACE OF MOTHER (State or Country),

*Ill.*

### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Swift*

(Address) *3410 Fairview Ave.*

#### 15-

Filed *Jan 11 1915* HARRY O. ANDREWS, Registrar.

### MEDICAL CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

*Jan 9 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 2 1914* to *Jan 9 1915*, that I saw her alive on *Jan 9 1915*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of intestine*  
*Exploratory laparotomy*  
(Duration) *2* yrs. *2* mos. *2* ds.

#### CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.

(Signed) *Marion M. Starr*  
*Jan 9 1915* (Address) *Church Homes Bldg.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *4* mos. *7* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Not known*

Former or usual residence *Roguel Heights - Balt*

#### 19-PLACE OF BURIAL OR REMOVAL,

*Elizabeth W. Swift*  
*W. H. Woodruff*

#### 20-DATE OF BURIAL,

*Jan 11 1915*  
ADDRESS *North Ave*



C81774

## HEALTH DEPARTMENT—CITY OF BALTIMORE

108 C81774

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *University Hosp*)ST.: *4* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Mrs. Maggie Allison*)

St.: ..... yrs., ..... mos., ..... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Katherine Huber*(Address) *Genarson, Ind.*

15 JAN 11 1915

HARRY O. ANDREWS,

Filed....., 191.....

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

I HEREBY CERTIFY That I attended deceased from

Jan 9 1915 to Jan 10 1915

that I saw her alive on Jan 10 1915

and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

*Acute Appendicitis*

(Duration) ..... yrs., ..... mos., ..... ds.

CONTRIBUTORY (Secondary) *Abortion (2 mos)*

(Duration) ..... yrs., ..... mos., ..... ds.

(Signed) *W. D. M. D.*Jan 10, 1915 (Address) *Univ. Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted if not at place of death? *Perry Hall, Baltimore*

Former or usual residence " " " "

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Michaels Cemetery**Jan 12 1915*

20-UNDERTAKER

ADDRESS

*Frank Lassman* *Baltimore, Ind.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH **BAHNEMANN GENERAL HOSPITAL,**  
CITY OF BALTIMORE (No. **1122 N. MOUNT STREET,** St. **16** WARD)  
2-FULL NAME **MARGARET SMITH,**  
(Residence in Baltimore: No. **907 N. GILMORE STREET.** St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX **Female,** 4-COLOR OR RACE, **White,** 5-SINGLE, **Married,**  
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
6-DATE OF BIRTH, **September 21st, / 1877.**  
(Month) (Day) (Year)

7-AGE, **37 yrs. 3 mos. 18 ds.** If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, **Housewife,**  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), **Baltimore, Md.**

10-NAME OF FATHER, **Theodric W. Weems,**

11-BIRTHPLACE OF FATHER (State or Country), **Unknown,**

12-MAIDEN NAME OF MOTHER **Margaret Berry,**

13-BIRTHPLACE OF MOTHER (State or Country), **Maryland.**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Claude E. Smith,**

(Address) **907 N. Gilmore street,**

15-

Filed.....

191.....

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **January 8th, 1915.**  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry**  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said **inquiry** find that said deceased came to **her** death  
(Inquest, au-  
topsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

**SEPTICHAEMIA, CAUSED BY A SELF-INDUCED ABORTION.**

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Signed) **J. Indiraik Neupel** M. D.  
(Coroner.)

**Jan. 9th, 1915** (Address) **1103 Valley st.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.....

20-UNDERTAKER ADDRESS.....

NOTHING CONFIRMING LINK—THIS IS A PERMANENT RECORD

ADDRESS





## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81778

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81778

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

Residence in Baltimore: No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH

March

22<sup>nd</sup>

1891

## 7-AGE

23

yrs.

9

mos.

18

ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Baltimore City

## 10-NAME OF FATHER

Charles H. Miller

11-BIRTHPLACE OF FATHER  
(State or Country),

Baltimore Md

## 12-MAIDEN NAME OF MOTHER

Annie R. Hall

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant)

Clarence Young

(Address)

435 N. Curley St.

## 15-

JAN 11 1915

FILE

191

BUREAU OF HEALTH  
Baltimore

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

July

(Month)

10

(Day)

1915

(Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

July 5 1915, to July 10 1915.

that I saw ~~or~~ alive on July 15 1915.

and that death occurred, on the date stated above, at 2308 m.

The CAUSE OF DEATH\* was as follows:

Diphtheria

## CONTRIBUTORY (Secondary)

Cardiac Asthma

## (Signed) (Duration) yrs. mos. ds.

J. Miller N. White

July 15 1915. (Address) 1101 7<sup>th</sup> Bway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

## DATE OF BURIAL,

Jan. 11<sup>th</sup>, 1915

## 20-UNDERTAKER

George Schilling &amp; Sons

## ADDRESS

1126 E. Monument

4 P. M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81779

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore, No. *922 N. Caroline St.* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*white*

## 5-SINGLE,

MARRIED,

or

other

(If word.)

*Married*

## 6-DATE OF BIRTH

*Nov 2nd 1862*  
(Month) (Day) (Year)

## 7-AGE

*52 yrs. 2 mos. 6 ds.*

If LESS than 1 day.

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Clerk*9-BIRTHPLACE,  
(State or Country),*Baltimore City*

## 10-NAME OF FATHER

*Bernard McEwan*11-BIRTHPLACE OF FATHER  
(State or Country),*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Sarah Donohue*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ferdinand J. Young*(Address) *922 N. Caroline St.*

## 15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan. 8, 1915*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

*Jan 6, 1915, to Jan 8, 1915*that I saw him alive on *Jan 8, 1915*and that death occurred, on the date stated above, at *11:00 a.*

The CAUSE OF DEATH\* was as follows:

*Metabolic Regurgitation and Chronic Interstitial Nephritis*  
(Duration) *adverse known*CONTRIBUTORY  
(Secondary)(Duration) *2 yrs. 2 mos. 6 ds.*(Signed) *Edward P. Smith* M. D.*Jan 8, 1915* (Address) *Mercy Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds. *Life*Where was disease contracted, if not at place of death? *922 N. Caroline St.*Former or usual residence *922 N. Caroline St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Cathedral Cemetery*

## DATE OF BURIAL,

*Jan 11th 1915*

## 20-UNDERTAKER

*George Schilling & Sons 1126 E Monument*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81780

## CERTIFICATE OF DEATH.

79 C81780

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## PARENTS.

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25th 1914, to Jan. 9th 1915, that I saw him alive on Jan. 8th 1915, and that death occurred, on the date stated above, at 7 a. m. The CAUSE OF DEATH\* was as follows:

Vascular Heart Disease  
Nutritional Regurgitation  
(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) Edw. M. Simpson, M. D.  
Jan. 9th 1915 (Address) 5 N. Kensington St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Greenmount Cemetery

Jan. 12th 1915

## 20-UNDERTAKER

## ADDRESS

George Schilling Adams

1126 E. Monument St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

17. I HEREBY CERTIFY, That I attended deceased from Jan 5<sup>th</sup> 1915, to Jan 9<sup>th</sup> 1915, that I saw him alive on Jan 9<sup>th</sup> 1915, and that death occurred, on the date stated above, at 8:15 a.m. The CAUSE OF DEATH\* was as follows:

Arterio Sclerosis, Arteriosclerosis, (Duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Hypertrophy Prostate Gland Prostatic Gland (Duration) yrs. mos. ds. (Signed) E. J. Jones M. D. Jan 10, 1915 (Address) 72802 Roslyn, Va.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81782

C81782

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 Madison

ST. 11

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Mary Catharine Connelley

(Residence in Baltimore: No. 1020 Madison

Str.: yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

July

7

1830

(Month)

(Day)

(Year)

7 AGE

84

yrs.

4

mos.

2

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

md

10 NAME OF FATHER

Wm. C. Connelley

11 BIRTHPLACE OF FATHER (State or country)

Conn.

12 MAIDEN NAME OF MOTHER

Gibson

13 BIRTHPLACE OF MOTHER (State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ann M. Connelley

(Address)

1020 Madison

15

Filed

191

HARRY O. ANDREWS, REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

9

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1914, to Jan, 1915.

that I saw her alive on Jan, 1915, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH\* was as follows:

Parelysis - Valvular Dis. of Heart

8 mo (Duration) yrs. mos. ds.

Contributory arterio-sclerosis (SECONDARY) senility

(Duration) yrs. mos. ds.

(Signed) G. Lane Daneyhill M. D.

Jan 10, 1915 (Address) 1103 Madison

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

January 12, 1915

20 UNDERTAKER

Henry W. Jenkins & Sons Co. Orchard Sts.

C81783

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81783

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *508 S. Montford Ave* ST.; *1* WARD)

FULL NAME

(Residence in Baltimore: No. *508 S. Montford Ave* St.; yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Single*

6-DATE OF BIRTH,

*Feb. 2nd 1911*  
(Month) (Day) (Year)

7-AGE,

*3 yrs. 11 mos. 7 da.*

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 11 1915

Filed

191

BARRY O. ANDREWS,

Burial Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Feb 10 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 4* 1915, to *Jan 10* 1915, that I saw her alive on *Jan 10* 1915, and that death occurred, on the date stated above, at *9:15 p.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria*  
*& Sepsis*  
(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) *C. H. Rother* M. D.  
*1015*, 1015. (Address) *1015 S. Montford Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Catharon Cem.**Jan 11, 1915*

20-UNDERTAKER

ADDRESS

*W. J. Sander Son**2101 Platt*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81784

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81784

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

111 N. Stricker

ST. 19 WARD)

## 2-FULL NAME

Geraldus S. Allen

Residence in Baltimore: No.

111 N. Stricker

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Jan 13<sup>th</sup>, 1859  
(Month) (Day) (Year)

7-AGE,

55 yrs. 11 mos. 27 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

Retired

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Retail Tobacco Store

9-BIRTHPLACE,

(State or Country),

Balto.

10-NAME OF FATHER,

Geraldus S. Allen

11-BIRTHPLACE

OF FATHER  
(State or Country),

Balto.

12-MAIDEN NAME

OF MOTHER

Martha F. Fincher

13-BIRTHPLACE

OF MOTHER  
(State or Country),

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

W. C. Allen

(Address).

111 N. Stricker

15-JAN 11 1915

HARRY O. ANDREWS,

Filed.....

101. Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 10, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10 1915, to Jan 10 1915,

that I saw him alive on Jan 10 1915,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH\* was as follows:

Heart Failure.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Probably Stricture of Oesophagus

(Duration) 20 yrs.....mos.....ds.

(Signed).....

W. F. Smith

M. D.

Jan 11, 1915. (Address) 111 N. Stricker

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Garden Park

Jan 12, 1915

20-UNDERTAKER

E. M. Mitchell

ADDRESS

111 N. Stricker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

81785

C81785

1 PLACE OF DEATH

64 REGISTERED No. C

CITY OF BALTIMORE (No. 1912 Edwood Pl.

ST. 8

WARD)

2 FULL NAME Frances Thomas

(Residence in Baltimore: No. 1912 Edwood Pl.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

about 60 or 65 yrs. 15 mos. 1 day (Month) (Day) (Year)

7 AGE

about 60 or 65

yrs.

mos.

ds.

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Home

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Davidson

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace Philip

(Address)

1912 Edwood Pl.

15 JAN 11 1915

Burial Permit Officer

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 8, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 7, 1915, to Jan 8, 1915,

that I saw her alive on Jan 8, 1915,

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Elmer G. Hall

M. D.

Jan 9, 1915

(Address)

1617 E. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Jan 11, 1915

20 UNDERTAKER

E. J. Hiedfeldt

ADDRESS

1617 E. North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

C81786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10

C81786

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *2803 St Paul* ST. *12* WARD)

2-FULL NAME

*Olivia Taylor*

Residence in Baltimore: No. *2803 St Paul* St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

*Married*

6-DATE OF BIRTH

*May 31, 1838*  
(Month) (Day) (Year)

7-AGE

*76* yrs. *7* mos. *9* ds. or min.?  
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*At Home*

9-BIRTHPLACE  
(State or country)

*Balto Co. Md*

10-NAME OF FATHER

*Benjamin Baxter*

11-BIRTHPLACE OF FATHER  
(State or country)

*Balto Co. Md*

12-MAIDEN NAME OF MOTHER

*Nancy Read*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Henry Kirk Field*

(Address) *2803 St Paul St*

15-

*JAN 11 1915*  
Filed *191*

*HARRY O. ANDREWS,*

*Barial Permit Clerk*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan 10, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 1*, 1914, to *Jan 10*, 1915,

that I saw her alive on *Jan 9*, 1915, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*  
*following influenza*

(Duration) yrs. *1* mos. *10* ds.

Contributory (SECONDARY)

*Cardiac Asthenia*

(Duration) yrs. *2* mos. *2* ds.

(Signed),

*Herbert E. Zepke* M. D.

*Jan 10*, 1915. [Address] *3050 W. North Ave*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Baltimore Cemetery*

DATE OF BURIAL

*Jan 12, 1915*

20-UNDERTAKER

*H. E. Hughes*

ADDRESS

*17 S. Bay*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81787

170 C81787

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *114 N Chapel*

ST.:

REGISTERED NO. C

WARD) *6*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Joseph Butta*(Residence in Baltimore: No. *114 N Chapel*

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Married*

## 6-DATE OF BIRTH.

*October 29, 1858*  
(Month) (Day) (Year)

## 7-AGE.

*56 yrs. 2 mos. 11 ds.*If LESS than 1 day,  
hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Potter*9-BIRTHPLACE,  
(State or Country).*Germany*

## 10-NAME OF FATHER.

*Matthews N Butta*11-BIRTHPLACE OF FATHER  
(State or Country).*Germany*

## 12-MAIDEN NAME OF MOTHER

*Mary Robb*13-BIRTHPLACE OF MOTHER  
(State or Country).*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Butta*(Address) *114 N Chapel*

15- JAN 11 1915

HARRY O. ANDREWS,

Filed..... 191... Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 9, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 12* 1914, to *Jan 9* 1915, that I saw him alive on *Jan 8* 1915, and that death occurred, on the date stated above, at *7 P. m.* The CAUSE OF DEATH\* was as follows:*Asplenia Chronica*

(Duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *C. W. Ashley* M. D.*Jan. 9, 1915* (Address) *1005 Park Pic av*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

*Corn Lawn*

## DATE OF BURIAL.

*January 12 1915*

## 20-UNDERTAKER

*Wendell Kappel & Son*

## ADDRESS

*378 N. Main St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81788

C81788

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Circle 7 Second St.* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Mrs. Louisa Hallitt*(Residence in Baltimore: No. *620 W. Saratoga* St.; — yrs. — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Widow*

## 6-DATE OF BIRTH,

*June 20, 1860*

(Month)

(Day)

(Year)

## 7-AGE,

*54* yrs. *6* mos. *20* ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*Bonding House Help*9-BIRTHPLACE,  
(State or Country),*Portland*

## 10-NAME OF FATHER,

*Joseph Hallitt*11-BIRTHPLACE OF FATHER  
(State or Country),*Pa*

## 12-MAIDEN NAME OF MOTHER

*Mary Lawler*13-BIRTHPLACE OF MOTHER  
(State or Country),*Portland Pa*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edw. C. Hunselhor*(Address) *2683 St. Benedict*

JAN 11 1915

HARRY O. ANDREWS,

Filed..... 191... Burial Permit Clerk, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 10, 1915*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 8, 1914, to Jan 10, 1915,*that I saw him alive on *Jan 9, 1915,*and that death occurred, on the date stated above, at *72:30 m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Suppurative Hepatitis*CONTRIBUTORY  
(Secondary)*Hypostatic Pneumonia*(Signed) *H. K. Gossard* M. D.191... (Address) *117 W. Saratoga St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *630 W. Saratoga St*

## 19-PLACE OF BURIAL OR REMOVAL,

*Bouldsburg, Pa.*

## DATE OF BURIAL,

*Jan 11, 1915*

## 20-UNDERTAKER

*Wendell Dappell & Son 378 Penn St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81789

## CERTIFICATE OF DEATH. (167) X 165

C81789

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Dorothy Fleischman* *Pence Springs W. Va* St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *Single*, WIDOWED, OR DIVORCED. (Write the word.)

## 6-DATE OF BIRTH,

*Jan* *27*, *1911*  
(Month) (Day) (Year)

## 7-AGE,

*3* yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *child*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

*West Va*

## 10-NAME OF FATHER,

*Joseph B. Fleischman*

## 11-BIRTHPLACE OF FATHER (State or Country),

*W. Va.*

## 12-MAIDEN NAME OF MOTHER

*Cora Cruzer*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*W. Va.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R. J. Heard*(Address) *Johns Hopkins Hospital*

## 15-

JAN 11 1915

HARRY O. ANDREWS,

Filed. 191. *Barial Peratt Clerk* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* *10*, *1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 9* *1915* to *Jan 10* *1915*,  
that I saw her alive on *Jan 10* *1915*,  
and that death occurred, on the date stated above, at *3:30 p.m.*

## The CAUSE OF DEATH\* was as follows:

*Stricture of Esophagus,*  
*secondary to Scleroderma, sp.*  
*(Accidental)*  
(Duration) .... yrs. .... mos. .... ds.

## CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) *Walter R. Reid* M. D.*Jan 10, 1915* (Address) *24 Hoep*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. *2* ds. In the State .... yrs. .... mos. *2* ds.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Pence Springs W. Va*

## 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Pence Springs W. Va* *JAN 11 1915*

## 20-UNDERTAKER

## ADDRESS

*C. M. Underwood 16106 Chase*

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81790

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 1517 Prichman St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Samh A Brooks(Residence in Baltimore: No. 1517 Prichman St St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX,

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,  
...hrs. or ...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- 
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 11 1915

HARRY C. ANDREWS,

Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Dec 30 1914, to Jan 10 1915,

that I saw her alive on Jan 10 1915,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY  
(Secondary)

(Signed)

Jan 11, 1915. (Address) 1209 Prichman St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

UNDERTAKER

ADDRESS



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19  
C81791

PLACE OF DEATH  
CITY OF BALTIMORE (No. 410 Druidhill ave.  
FULL NAME Charles Lookman,  
(Residence in Baltimore: No. 410 Druidhill ave.

ST. 17 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male,	4-COLOR OR RACE, Colored,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,
6-DATE OF BIRTH, January 8th, 1848. (Month) (Day) (Year)		
7-AGE, 66 yrs. 0 mos. 0 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Coachman, (b) General nature of industry, business, or establishment in which employed (or employer) retired 3 yrs.		
9-BIRTHPLACE, (State or Country), Maryland,		
PARENTS.	10-NAME OF FATHER, John Lookman,	
	11-BIRTHPLACE OF FATHER (State or Country), Maryland,	
	12-MAIDEN NAME OF MOTHER Unknown,	
	13-BIRTHPLACE OF MOTHER (State or Country), Unknown.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Ringgold,

(Address) 1463 N. Carey st.

15- JAN 11 1915 HARRY O. ANDREWS,  
Filed. 191. Burial Permit Clerk  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
January 8th, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.  
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Probably atheromatous changes in the Coronary arteries.

(Duration) yrs. mos. ds.

CONTRIBUTORY Arterio-sclerosis,  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) Frederick Kumpel, M. D.  
(Coroner.)

Jan. 9th 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

James H. Dennis 1303 Chestnut

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81792

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 4 WARD)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

## 6-DATE OF BIRTH,

December 6, 1842  
(Month) (Day) (Year)

## 7-AGE,

72 yrs. 1 mos. 5 ds.

If LESS than 1 day,  
....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).....

Retired

9-BIRTHPLACE,  
(State or Country),

New Jersey

10-NAME OF  
FATHER,

Cornelius Van Vorst

11-BIRTHPLACE  
OF FATHER  
(State or Country),

New Jersey

12-MAIDEN NAME  
OF MOTHER

Annette Roosevelt

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

New York

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Sarah G. Van Vorst

(Address)

Cambridge, Maryland

## 15-

JAN 11 1915

HARRY O. ANDREWS,

Filed

191

Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 11, 1915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1915, to Jan 11, 1915,

that I saw him alive on Jan 11, 1915,

and that death occurred, on the date stated above, at 5:10 a.m.

## The CAUSE OF DEATH\* was as follows:

Pneumonia Lobar

(Duration)..... yrs. .... mos. 9 ds.

CONTRIBUTORY  
(Secondary)

(Duration) 3 yrs. .... mos. .... ds.

(Signed) J. A. Gorman M. D.

1-11-1915 (Address) 117 N. Saratoga St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. 9 ds. In the State yrs. .... mos. 9 ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

Cambridge, Md

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Cambridge, Dorchester Co., Md

Jan 13, 1915

## 20-UNDERTAKER

## ADDRESS

Stewart-Mowen Company

108 W North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81793

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81793

## CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1216 S. CAREY STREET,

ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME JOHN LINDE,

(Residence in Baltimore: No. 1216 S. CAREY STREET. St.; 0 yrs. 9 mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3-SEX Male, 4-COLOR OR RACE White, 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married, (Write the word)

6-DATE OF BIRTH

May 10th, 1847.

(Month) (Day) (Year)

7-AGE

67 yrs. 8 mos. 0 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Shoemaker,  
(b) General nature of industry, business, or establishment in which employed (or employer) retired 5 years.

9-BIRTHPLACE (State or country)

Russia,

PARENTS

10-NAME OF FATHER

Martin Linde,

11-BIRTHPLACE OF FATHER (State or country)

Russia,

12-MAIDEN NAME OF MOTHER

Anna Schalkw,

13-BIRTHPLACE OF MOTHER (State or country)

Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Juliana B. Linde, wife,

(Address) 1216 S. Carey street.

15-

JAN 11 1915

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

16-DATE OF DEATH

January 10th, 1915.

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 19th 1914, to January 10, 1915. that I saw him alive on January 9th, 1915, and that death occurred, on the date stated above, at 8 a. m. The CAUSE OF DEATH\* was as follows:

PULMONARY TUBERCULOSIS,

(Duration) Indefinite, ds.

Contributory (SECONDARY)

(Signed)

J. Frederick Hempel M. D.  
Jan. 11th 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted.  
If not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery Jan. 12, 1915  
20-UNDERTAKER ADDRESS  
Geo. L. Schwab & Co. 2401 Thacker Ave.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81794

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81794

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1227 Durst Alley

FULL NAME John J. Hooper

(Residence in Baltimore: No. 408 Grindall St

REGISTERED NO. C

ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

28 yrs., 7 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, May 31, 1886 (Month) (Day) (Year)

7-AGE, 28 yrs., 7 mos. 9 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, William Hooper

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary A Walton

13-BIRTHPLACE OF MOTHER (State or Country), 408 Grindall St

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hooper (Address) 408 Grindall St

15- JAN 11 1915 HARRY O. ANDREWS, Registrar. Filed, 191. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 9, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to His death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

Suicide

Pistol shot wound in Head

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Signed) E. J. G. (Coroner.) Sudden

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, 1-12-1915

20-UNDERTAKER, E. B. H. ADDRESS, 115 E. Neal St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81795

## CERTIFICATE OF DEATH.

109 C81795  
REGISTERED NO. C

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *Mercy Hospital* ST. *11* WARD)  
2-FULL NAME *James E. Myer*  
(Residence in Baltimore: No. *1118 Brevard St.* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, ~~MARRIED~~ *Married*  
6-DATE OF BIRTH. *Oct 25, 1893*  
(Month) (Day) (Year)  
7-AGE, *61* yrs. *2* mos. *16* ds. If LESS than 1 day, .... hrs. or .... min.

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Firmman*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md.*

PARENTS.  
10-NAME OF FATHER, *Geo. H. Myer*  
11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*  
12-MAIDEN NAME OF MOTHER, *Mary Myers*  
13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary C. Myer*  
(Address) *1118 Brevard St.*

15- *JAN 11 1915* HARRY O. ANDREWS, Registrar.  
Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan. 10, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 1* 1915, to *Jan 10* 1915, that I saw him alive on *Jan 10* 1915, and that death occurred, on the date stated above, at *1:05* m.

The CAUSE OF DEATH\* was as follows:

*Myocardial Infarction - Bilateral*  
(Duration) *Unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Operation (Local Anesthesia)*

(Signed) *Edward P. Smith* M. D.  
*Jan. 10, 1915* (Address) *Mercy Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds. *9* *Life*

Where was disease contracted, if not at place of death? *Do not know*

Former or usual residence *1118 Brevard St.*

19-PLACE OF BURIAL OR REMOVAL, *Mt Olivet Cem*

DATE OF BURIAL, *Jan. 13, 1915*

20-UNDERTAKER, *Harry W. Ehlert*

ADDRESS *1944 W. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81796

## CERTIFICATE OF DEATH.

REGISTERED No. C

C81796

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1735 N. Fulton Avenue St. 15 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1735 N. Fulton Avenue St. 35 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)Widow

6-DATE OF BIRTH,

September 4th, 1895

(Month)

(Day)

(Year)

7-AGE,

66 yrs. 4 mos. 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Not any  
Not any9-BIRTHPLACE,  
(State or Country).Perry Co. Pa.

10-NAME OF FATHER,

Christian Stouffer11-BIRTHPLACE OF FATHER  
(State or Country).Perry Co. Pa.

12-MAIDEN NAME OF MOTHER

Mary Jane Kays13-BIRTHPLACE OF MOTHER  
(State or Country).Perry Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Leroy C. Papp  
(Address) 1735 N. Fulton Avenue

15-

JAN 11 1915.

Filed

191

Burial Permit Clerk

Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 9th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9th 1915, to Jan 9th 1915, that I saw her alive on Jan 9th 1915, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage(Duration) — yrs. — mos. 1 ds.CONTRIBUTORY  
(Secondary)(Duration) 2 yrs. — mos. — ds.(Signed) William H. Harrison M. D.Jan 9th 1915. (Address) 1701 N. Fulton Avenue

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery Jan 12, 1915

20-UNDERTAKER

B. Wipperf 2238 Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81797

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15 JAN 11 1915

Filed

191

HARRY O. ANDREWS  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on  
and that death occurred, on the date stated above, at  
The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death  
Where was disease contracted?  
If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

C81798

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81798

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

Residence in Baltimore: No.

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH May 3, 1856 (Month) (Day) (Year)

7-AGE 58 yrs. 8 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None Retired

9-BIRTHPLACE (State or country) Ecty

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Emma Riggs

(Address) 1701 Harlem

15. JAN 11 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 9, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1914, to Jan 9, 1915, that I saw him alive on Jan 9, 1915, and that death occurred, on the date stated above, at The CAUSE OF DEATH\* was as follows:

Coronary of Heart (Duration) 12 yrs. mos. ds

Contributory cardiac Dilatation (SECONDARY) (Duration) yrs. mos. ds

(Signed) Herbert C. Blake M. D. Jan 10, 1915 (Address) 1014 N. to Jay St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lorraine Cem Jan 12, 1915

20-UNDERTAKER W. J. Tuckner & Sons ADDRESS North Pa

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81799

C81799

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital*, 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Della Howard Co. Md* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE,

*Black*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

....., 1.....  
(Month) (Day) (Year)

## 7-AGE,

*57* yrs. — mos. — ds. If LESS than 1 day,  
.....hrs. or.....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,  
(State or Country),*Maryland.*

## PARENTS.

## 10-NAME OF FATHER,

*Do not know*11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*R. L. Wright, Supt.*(Address).....*Md General Hospital*

## 15-

JAN 11 1915

Filed....., 191.....  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*....., 191*5*.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 17* 191*4*, to *Jan 8* 191*5*,that I saw her alive on *Jan 8* 191*5*,and that death occurred, on the date stated above, at *4:50 P.* m.

## The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

(Duration)..... yrs. .... mos. .... ds.

CONTRIBUTORY  
(Secondary)*Myocardial Degeneration*

(Duration)..... yrs. .... mos. .... ds.

(Signed).....*Chas. C. Ayres*..... M. D.*Jan 8*...., 191*4*. (Address).....*Md General Hospital*.....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....*Della Howard Co. Md*.....

## 19-PLACE OF BURIAL OR REMOVAL,

*JAN & Budd*....., 191.....

## 20-UNDERTAKER

*Commissioner Health* ADDRESS

JOHNS HOPKINS HOSPITAL

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81800

## CERTIFICATE OF DEATH.

152  
REGISTERED NO. C

C81800

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *510 Scott*ST.; *21* WARD)(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
*10th 20th*

## 2-FULL NAME

(Residence in Baltimore: No. *510 Scott*

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*5-SINGLE, *single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH

*June 10, 1915*  
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,

*10 hrs. or 30 min.*

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE,

(State or Country), *Baltimore Md.*

## PARENTS.

10-NAME OF FATHER

*Clarence C. Cadell*

11-BIRTHPLACE OF FATHER

(State or Country), *Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Helen Chaney*

13-BIRTHPLACE OF MOTHER

(State or Country), *Baltimore Md.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clarence C. Cadell*(Address) *510 Scott St.*

15-

JAN 11 1915

HARRY O. ANDREWS,

Filed.....

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*June 10, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*June 10, 1915*, to *June 10, 1915*that I saw him alive on *June 10, 1915*,and that death occurred, on the date stated above, at *2:00* m.

The CAUSE OF DEATH\* was as follows:

*Arranged Lachar*

(Duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary) *Exhaustion*

(Duration) yrs. mos. ds.

(Signed) *J. M. Lamm* M. D.*June 10, 1915* (Address) *826 N. Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Hudson Park Cemetery* *June 12, 1915*

## 20-UNDERTAKER

ADDRESS

*George J. Smith* *715 E. 1st St.*

Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CS1801

# HEALTH DEPARTMENT-CITY OF BALTIMORE

## CERTIFICATE OF DEATH

CS1801

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

11-LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JAN 11 1915

ROBERT J. ZRAUTER,

Sanitary Permit Clerk

Filed

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease  
(Myocardial Infarction)  
(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY)

(Signed) J. J. Egan M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mary Point Va.

Jan 12, 1915

20-UNDERTAKER

ADDRESS

W. W. Bouton 2301 Green

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81802

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3445 Frederick Ave.* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

## 2-FULL NAME

*Clara Fell*(Residence in Baltimore: No. *3445 Frederick Ave.* St.; *30* yrs.,  mos.,  ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*Unknown*, 18*48*  
(Month) (Day) (Year)

## 7-AGE,

*67* yrs.,  mos.,  ds. If LESS than 1 day,  hrs. or  min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Servant*

## 9-BIRTHPLACE, (State or Country),

*Germany*

## 10-NAME OF FATHER,

*Unknown*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Casey*(Address) *3547 Fredk. Ave.*15-*JAN 11 1915*  
Filed

ROBERT J. BRADY, Registrar.

191. Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 9*, 191*5*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 6* 191*5*, to *Jan 9* 191*5*, that I saw *her* alive on *Jan 9* 191*5*, and that death occurred, on the date stated above, at *11:45* p.m.

The CAUSE OF DEATH\* was as follows:

*Acute Croupal Pneumonia*(Duration)  yrs., *4* mos.,  ds.

## CONTRIBUTORY (Secondary)

(Duration)  yrs.,  mos.,  ds.(Signed) *Howard W. Jones*, M. D.*Jan 10*, 191*5*. (Address) *Dwight St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death  yrs.,  mos.,  ds. In the  State  yrs.,  mos.,  ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

*New Cathedral Cem.* *Jan. 12<sup>th</sup>*, 191*5*

## 20-UNDERTAKER

## ADDRESS

*Charles W. Hill* *Federick Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81803

C81803

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's chf. Asy.* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Martin Gregory*Residence in Baltimore: No. *St. Vincent's chf. Asylum* St.: *14* yrs., *1* mos. *10* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *Oct. 28<sup>th</sup>*, *1914*.  
(Month) (Day) (Year)

7-AGE, *2* yrs., *10* mos., *10* ds. IF LESS than 1 day, ....hrs. or ....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division*

15- *JAN 11 1915* *ROBERT E. BRADY*  
Filed *191* *Marial Permit Clerk*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 7<sup>th</sup>*, *1915*.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *January 5*, 1915, to *January 7<sup>th</sup>*, 1915, that I saw him alive on *January 7<sup>th</sup>*, 1915, and that death occurred, on the date stated above, at *10.30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho-pneumonia*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY *Malnutrition*  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) *Leonard M. C. Parker* M. D.  
*Jan 8*, 1915 (Address) *825 N. Fulton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral* DATE OF BURIAL, *Jan. 11, 1915*

20-UNDERTAKER *Martin Faherty & Sons* ADDRESS *106 Lafayette*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Effect statement of OCCUPATION is very important. See instructions on back of certificate.



# C81804 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1900 Penrose Ave* St. *20* WARD)

REGISTERED NO. C

2-FULL NAME

*Amanda Bentz*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1900 Penrose Ave*

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female White*

4-COLOR OR RACE,

5-SINGLE, *Widow*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*Sept 25, 1836*  
(Month) (Day) (Year)

7-AGE,

*78* yrs. *3* mos. ds.

If LESS than 1 day,  
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*At Home*

9-BIRTHPLACE,

(State or Country),

*Philadelphia Pa.*

10-NAME OF FATHER,

*Isaiah De Haven*

11-BIRTHPLACE OF FATHER

(State or Country),

*Philadelphia*

12-MAIDEN NAME OF MOTHER

*unknown*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Philadelphia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs Sarah Steis*

(Address)

*1900 Penrose Ave*

15-

FILED

JAN 11 1915

DEPT. OF HEALTH

Permit Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 10<sup>th</sup>, 1915*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*, au-

*Inquest* and that said deceased came to *her* death  
topsy or inquiry, on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Chronic Brights Disease*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Sam'l Winters* M. D.

*Jan 10<sup>th</sup>, 1915* (Address) *2302 Madison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Cemetery Jan 12, 1915*

20-UNDERTAKER

ADDRESS

*William Cook 502 E. North Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81805

REGISTERED NO. C.

C81805

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Powhatan Ave. ST. 15 WARD)

2-FULL NAME Emma Warton James (nee Espey)

(Residence in Baltimore: No. 3508 Powhatan Ave., Forest Park St.; 65 yrs. 6 mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE MARRIED Divorced. WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH July 23, 1849 (Month) (Day) (Year)

7-AGE 65 yrs. 6 mos. 5 ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work House duties. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, Md.

10-NAME OF FATHER Wm. S. Espey.

11-BIRTHPLACE OF FATHER (State or country) Pennsylvania

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Ross Gould  
(Address) 3508 Powhatan Ave.

JAN 11 1915

ROBERT KRAUTH,  
Burial Permit Clerk.  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 10, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1915, to Jan 10, 1915, that I saw her alive on Jan 10, 1915, and that death occurred, on the date stated above, at 6 P. m.  
The CAUSE OF DEATH\* was as follows:

Acute Cardiac dilatation

(Duration) yrs. mos. ds. 2 ds.  
Contributory (SECONDARY) myocarditis

(Signed) Arthur L. Thompson, M. D.  
Jan 10, 1915 [Address] 2506 Garrison St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore

Jan 13, 1915

20-UNDERTAKER

ADDRESS

William Cook

507 E North

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81806

C81806

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *613 W. Barre* ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Valentine Bauer*(Residence in Baltimore: No. *613 W. Barre* 1St.; *52* yrs., *C* mos. *C* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED, *Married*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Jan 7, 1857*  
(Month) (Day) (Year)

## 7-AGE,

*58* yrs., *C* mos., *3* ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Star Keeper*9-BIRTHPLACE,  
(State or Country),*Germany*

## PARENTS.

## 10-NAME OF FATHER,

*John Bauer*11-BIRTHPLACE OF FATHER  
(State or Country),*Germany*

## 12-MAIDEN NAME OF MOTHER

*Elizabeth Zuer*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Catherine J. Bauer*(Address) *613 W. Barre*

## 15-

Filed

JAN 11 1915

HUBERT J. KELTNER,

Serial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*1* / *10* / *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb. 1, 1915*, to *Jan 10, 1915*, that I saw him alive on *Jan 10, 1915*, and that death occurred, on the date stated above, at *9 A.M.*

The CAUSE OF DEATH\* was as follows:

*Ischemic Heart Disease & asthma*(Duration) *one* yrs. *C* mos. *C* ds.CONTRIBUTORY  
(Secondary)*Exhaustion*(Duration) *one* yrs. *C* mos. *C* ds.(Signed) *W. B. Hall* M. D.*Jan. 11, 1915* (Address) *W. B. Hall*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Western Cemetery*

## DATE OF BURIAL,

*Jan 13, 1915*

## 20-UNDERTAKER

*Jos. J. Jendrowski*

## ADDRESS

*217 S. Penn*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81807

151 C81807

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *312 E. Exeter* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *312 E. Exeter St* St.; yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*Jan 9, 1915*  
(Month) (Day) (Year)

## 7-AGE,

*2* yrs. mos. ds.

If LESS than 1 day, ....hrs. or ....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*  
*Infant*

## 9-BIRTHPLACE, (State or Country),

*Baltimore*

## 10-NAME OF FATHER,

*Vincent Chionpoglio*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Italy*

## 12-MAIDEN NAME OF MOTHER

*Comptino Janoroko*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Italy*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Vincent Chionpoglio*  
*312 E. Exeter St*Filed *JAN 11 1915* 191REPORTER: *ERASTUS*  
Mortual Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 11, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 9, 1915*, to *Jan 11, 1915*, that I saw h *alive* on *Jan 11, 1915*, and that death occurred, on the date stated above, at *1* m.

The CAUSE OF DEATH\* was as follows:

*Congenital weakness*(Duration) .... yrs. .... mos. *3* ds.

## CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed)

*J. J. Valentini* M. D.  
*Jan 11, 1915* (Address) *100 Bond St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Holy Rosary*

## DATE OF BURIAL,

*Jan 12, 1915*

## 20-UNDERTAKER

*Jacob Falkowski*

## ADDRESS

*418 S Bond St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

081808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *2007 E. Biddle* ST.; *8* WARD)  
2-FULL NAME *Margaret A. Dwyer*  
(Residence in Baltimore: No. *2007 E. Biddle* St.; *50* yrs., — mos. — ds.)

REGISTERED NO. C

081808

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, *Single*  
(Write the word.)  
6-DATE OF BIRTH, *Unknown*, 1862  
(Month) (Day) (Year)

7-AGE *52* yrs. — mos. — ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country) *New Orleans*

10-NAME OF FATHER *John Dwyer*

11-BIRTHPLACE OF FATHER (State or Country) *Ireland*

12-MAIDEN NAME OF MOTHER *Margaret M. Laughlin*

13-BIRTHPLACE OF MOTHER (State or Country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Miss Michael M. Howe*  
(Address) *2007 E. Biddle St.*

15- *JAN 11 1915* *JOHN T. KEATING* *Serial Permit Clerk*  
Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 9<sup>th</sup>*, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *December 30 1914*, to *January 8 1915*, that I saw her alive on *January 8 1915*, and that death occurred, on the date stated above, at *3 P.* m. The CAUSE OF DEATH\* was as follows:

*Cerebral Pneumonia*  
(Duration)..... yrs..... mos..... ds.  
CONTRIBUTORY *Grav. Influenza*  
(Secondary) (Duration)..... yrs..... mos..... ds.  
(Signed)..... M. D.  
....., 191... (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?  
Former or usual residence.....

PLACE OF BURIAL OR REMOVAL *Mount Cemetery Plot 13* DATE OF BURIAL *Jan 13 1915*

UNDERTAKER *Wm. T. Cowley* ADDRESS *1187 Mt. Rainier*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81809

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81809

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

2. FULL NAME

Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

15. JAN 11 1915

ROBERT E. BRAUTER

Filed

REGISTRAR

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

C81810

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 S Calhoun St. 19

WARD)

2-FULL NAME

(Residence in Baltimore: No. 23 S Calhoun St. 62

St.; 62 yrs. 12 mos. 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

June 25, 1852  
(Month) (Day) (Year)

7-AGE

62 yrs. 6 mos. 14 ds. or min.?  
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Medical Doctor

9-BIRTHPLACE  
(State or country)

Germany

10-NAME OF FATHER

Carl Friedrich Seyferth

11-BIRTHPLACE OF FATHER  
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Sophie Braggemann

13-BIRTHPLACE OF MOTHER  
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Sophie Seyferth

(Address)

2310 Guilford Ave

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

January 9, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 8, 1914 to January 9, 1914, that I saw him alive on January 9, 1914, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Hypostatic Pneumonia

Contributory (SECONDARY)

Cirrhosis of Liver  
(Duration) yrs. 8 mos.

(Signed)

W. O. Neill M. D.

January 11, 1914 [Address] 108 N. Hollister

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery Jan. 12, 1914

17-UNDERTAKER

ADDRESS

George J. Smith 108 N. Hollister

JAN 11 1915

ROBERT K. KRATZER

Marial Permit Clerk

REGISTRAR



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murray & Child Ave. Hospital*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Murray & Child Ave. Hospital*)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Paul M. M. M.*(Address) *419 St. Paul St.*

15- JAN 11 1915

Filed..... 191

ROBERT J. KRAUTH

Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 6 1915*, to *Jan 10 1915*,that I saw her alive on *Jan 10 1915*,and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH\* was as follows:

*Intestinal Intoxication*(Duration)..... yrs..... mos. *4* ds.CONTRIBUTORY  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Harry Foster* M. D.*Jan 11, 1915* (Address) *Murray & Child Ave. Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *X* yrs. *15* ds. In the State *X* yrs. *29* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*London Park Cemetery* *Jan 12, 1915*

## 20-UNDERTAKER

## ADDRESS

*George J. Smith* *25 St. Paul St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81812

## CERTIFICATE OF DEATH

91

C81812

1-PLACE OF DEATH

CITY BALTIMORE (No

2-FULL NAME

Residence in Baltimore: No.

919 Elm Place  
Mary Bundy  
919 Elm Place

ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

Str.: yrs. mos. 11 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female Colored

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Dec 28, 1914  
(Month) (Day) (Year)

7-AGE

11 yrs. mos. 11 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE (State or country)

Balto. md

10-NAME OF FATHER

Wm Bundy

11-BIRTHPLACE OF FATHER (State or country)

Va

12-MAIDEN NAME OF MOTHER

Rosa Johnson

13-BIRTHPLACE OF MOTHER (State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rosa Bundy  
919 Elm Place

(Address)

15-

JAN 12 1915

HARRY O. ANDREWS,  
Burial Permit Clerk.

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 8th, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

January 7, 1915 to January 8, 1915.

that I saw her alive on January 8, 1915.

and that death occurred, on the date stated above, at 3:45 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Broncho Pneumonia

(Duration) yrs. mos. ds

Contributory (SECONDARY)

Exhaustion

(Duration) yrs. mos. ds

(Signed)

Geo. H. Lammiech M.D.

Jan 8th, 1915

(Address) 2215 N. Washington

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

Robert C. md

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Bur

Jan 12, 1915

20-UNDERTAKER

ADDRESS

John H. Foadwin

142 W. 11th St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXEMPT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

JAN 12 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. 13 WARD)

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

AGE

IF LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER (State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

HARRY O. ANDREWS,  
Burial Permit Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT DEATHS, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81814

PLACE OF DEATH

79 REGISTERED NO. C

C81814

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

Residence in Baltimore: No.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

4-COLOR OR RACE

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-JAN 12 1915

HARRY C. ADAMS,

Filed

191

Serial Permit Clerk.

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17.

I HEREBY CERTIFY, That I attended deceased from

May 16.

191

to

Jan 10 1915

that I saw him alive on

Jan 10 1915

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency.

Contributory  
(SECONDARY)

(Signed)

1/11

Mitral Insufficiency.

Admiral J. Fitzgerald M. D.

1118 Ohio St. N. W.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn

Jan 13 1915

20-UNDERTAKER

ADDRESS

John H. Treadwell

142 W. 11th St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *113 N. Carlton*)

2-FULL NAME

*James Brown*

(Residence in Baltimore: No. *113 N. Carlton St.*)

St.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*Colored*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

*Married*

6-DATE OF BIRTH

*Unknown*, 1846  
(Month) (Day) (Year)

7-AGE

*69* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Stevadore*

9-BIRTHPLACE

(State or Country),

*Md.*

10-NAME OF FATHER

*Sam'l Brown*

11-BIRTHPLACE OF FATHER

(State or Country),

*Md.*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Sarah Brown*

(Address)

*113 N. Carlton St.*

15-

JAN 12 1915

HARRY C. ANDREWS,

File

Marial Permit Clerk

Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Jan*, 1915  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*  
(Inquest, au-

*Inquest* find that said deceased came to *his* death  
(Inquest, autopsy or inquiry.)  
on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Sensitivity*  
(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Sam'l Brown* M. D.

*Jan 9th* 1915 (Address) *4302 Madison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. .... mos. .... ds. In the State.... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Mt. Auburn*

*Jan 12 1915*

20-UNDERTAKER

ADDRESS

*John H. Trudwin 142 W. 1st St.*



C81816

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

50  
REGISTERED NO. C

C81816

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1628 Canton Avenue* ST.; *2* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1628 Canton Avenue* St. *Life* yrs. *10* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Widow*

## 6-DATE OF BIRTH

*August 14th*, 18*50*  
(Month) (Day) (Year)

## 7-AGE,

*64* yrs. *4* mos. *26* ds.

If LESS than 1 day.

...hrs. ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

## 9-BIRTHPLACE, (State or Country),

*Balt. Md*

## PARENTS.

## 10-NAME OF FATHER,

*George Moller*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Margaret Moller*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Moller*(Address) *632 Fleet St*

## 15-

JAN 12 1915

Filed..... 191.....

BARRY O. ANDERSON,

Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

..... JAN. 9 - 1915 ..... 191.....  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1914, to *Jan 9* 1915, that I saw her alive on *Jan 9* 1915, and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH\* was as follows:

*Diabetes*  
*Insulin* (Duration) *10* yrs. *10* mos. *10* ds.

## CONTRIBUTORY (Secondary)

(Duration) *10* yrs. *10* mos. *10* ds.(Signed) *K. D. Moller* M. D.*Jan 9*, 1915. (Address) *2927 St. Paul St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*St. Anne*

## DATE OF BURIAL,

*Jan. 12, 1915*

## 20-UNDERTAKER

*H. Sander & Sons*

## ADDRESS

*111 Fleet St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81817

C81817

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Note*)

2-FULL NAME

(Residence in Baltimore: No. *Note*)

REGISTERED NO. C

ST. *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr.: *5* yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JAN 12 1915

HARRY O. ANDREWS,  
1915 Burial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *5* yrs. mos. ds. In the State *10* yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81818

C81818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8 E. Henrietta*

ST.: *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18c)

2-FULL NAME

*Peter J. Reith*  
*8 E. Henrietta*

(Residence in Baltimore: No.

St.: *45* yrs., mon. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

*Married*

6-DATE OF BIRTH,

*March 1, 1869*  
(Month) (Day) (Year)

7-AGE,

*45* yrs. *10* mos. *9* ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Baker*

9-BIRTHPLACE,  
(State or Country),

*Balto. Md*

10-NAME OF FATHER,

*Peter Reith*

11-BIRTHPLACE OF FATHER  
(State or Country),

*Ger.*

12-MAIDEN NAME OF MOTHER

*Frances Grappe*

13-BIRTHPLACE OF MOTHER  
(State or Country),

*Ger.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Reith*

(Address) *8 E. Henrietta st.*

15-

JAN 12 1915

HARRY O. ARDREWS

Filed

191

Regd. 1st. Permit to Bury

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Jan 10, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec 15 1914* to *Jan 10 1915*,

that I saw him alive on *Jan 10 1915*,

and that death occurred, on the date stated above, at *3 a* m.

The CAUSE OF DEATH\* was as follows:

*Acute Dilation of heart*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

*Mitral insufficiency*

(Duration) yrs. mos. ds.

(Signed) *Jas. J. O'Donnell* M. D.

*Jan 10, 1915* (Address) *107 E. Mt. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Cross bur. A. G. C. O. Jan 13, 1915*

20-UNDERTAKER

ADDRESS

*Jos. J. Herr 1914 E. Fayette*

C81819

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81819

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Mc Donough ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1012 Mc Donough

St.; 20 yrs., 3 mos. 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH,

September 30, 1894

(Month)

(Day)

(Year)

## 7-AGE,

20 yrs., 3 mos., 10 ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work...

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)...

Conductor

9-BIRTHPLACE,  
(State or Country),

Balls, Md

10-NAME OF  
FATHER,

George Max Boettger

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Germany

12-MAIDEN NAME  
OF MOTHER

Annie Bracken

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Balls - Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Boettger (mother)

(Address) 1012 Mc Donough St.

JAN 12 1915

HARRY O. ANGLITS,

Filed. 191... 101... Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 10, 1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Mr 20 1914, to Jan 10 1915

that I saw him alive on Jan 10 1915

and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH\* was as follows:

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81820

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81820

1 PLACE OF DEATH. *St Joseph's Hospital* ST. *9* WARD)  
 CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *9* WARD)  
 2-FULL NAME *Mary A. Nautz*  
 (Residence in Baltimore: No. *1417 Aisquith St.* St.: ..... yrs. .... mos. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single*  
 (Write the word.)  
 6-DATE OF BIRTH, *January 18, 1854*  
 (Month) (Day) (Year)  
 7-AGE, *60* yrs. *11* mos. *22* ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Seamstress*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

*Baltimore*

## 10-NAME OF FATHER,

*Andrew Nautz*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Theresa Mueller*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Elizabeth Mueller*  
 (Address) *1417 Aisquith St.*

JAN 12 1915

Filed.....

191.

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 10, 1915*  
 (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Aug 6 1914*, to *Jan 10 1915*,  
 that I saw her alive on *Jan 10 1915*,  
 and that death occurred, on the date stated above, at *3 P. m.*

## The CAUSE OF DEATH\* was as follows:

*Multilocular Cystic*  
*Adenoma Ovary.*  
*(Operation)*  
 (Duration)..... yrs. .... mos. .... ds.

## CONTRIBUTORY..... (Secondary)

(Duration)..... yrs. .... mos. .... ds.

(Signed)..... M. D.

*Jan 10 1915* (Address) *St Joseph's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence *1417 Aisquith St.*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Holy Redeemer Church* *Jan. 14 1915*

## 20-UNDERTAKER

## ADDRESS

*Jenny Hochman* *1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. If not known, state "Cause of Death" is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81821

## CERTIFICATE OF DEATH

REGISTERED NO. C

C81821

1 PLACE OF DEATH

CITY OF BALTIMORE (No

2 FULL NAME

Residence in Baltimore: No.

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.: yrs. 1 mos. 5 ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

December 8, 1914

(Month)

(Day)

(Year)

7 AGE

yrs. 1

mos. 5

ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto

10 NAME OF FATHER

Clarence A. Ramsey

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Catharine McKeary

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence Ramsey

(Address)

729 Harvey St

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 11, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1915, to Jan 11, 1915

(Month)

(Day)

(Year)

that I saw him alive on Jan 9, 1915

and that death occurred on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH\* was as follows:

Malnutrition  
(decomposition)

(Duration)

yrs. 1

mos. 5

ds.

Contributory (SECONDARY)

Exhaustion

(Duration)

yrs.

mos.

ds.

(Signed)

Jan 11, 1915

(Address)

213 W. Pratt

M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

In the

State

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Western Cem.

20 UNDERTAKER

Mr. J. J. Evans

& Sons

DATE OF BURIAL

Jan 12, 1915

ADDRESS

1428 S. Charles

St

JAN 12 1915

Filed

191

HARRY C. A. 26

Burial Permit Clerk

REGISTRAR

C81822

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81822

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *112 N Pine* ST. *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *112 N Pine* St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*Jan 10, 1853*  
(Month) (Day) (Year)

7-AGE,

*60 yrs. 7 mos. ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Sailor*

(b) General nature of industry, business, or establishment in which employed (or employer).

*at home*

9-BIRTHPLACE,

(State or Country),

*Ind.*

PARENTS.

10-NAME OF FATHER,

*Not known*

11-BIRTHPLACE OF FATHER (State or Country),

*Ind.*

12-MAIDEN NAME OF MOTHER

*Not known*

13-BIRTHPLACE OF MOTHER (State or Country),

*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *L. H. Green*(Address) *212 N. Pine St.*

15-

FILE

JAN 12 1915

HARRY O. ANDREWS,

101... Serial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 10, 1915*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*  
(Inquest, autopsy or inquiry.)and that said deceased came to *her* death  
(Inquest, autopsy or inquiry.)on the day stated above.  
The CAUSE OF DEATH\* was as follows:*Acute Cardiac Distention*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)*Organic Heart Disease*

(Duration) ... yrs. ... mos. ... ds.

(Signed)

*Jan 11, 1915* (Address) *113 N. Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

*Baltimore*

DATE OF BURIAL,

*Jan 12, 1915*

20-UNDERTAKER

*W. M. Moulton*

ADDRESS

*430 N. Green*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81823

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garret Hospital for Children*, WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1308 N Gilmore St*St.; *2* yrs., *7* mos., *1* da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*Unknown*, *1* (Month) (Day) (Year)

## 7-AGE,

*2* yrs., *7* mos., *1* da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country).

*Balto Md.*

## PARENTS.

## 10-NAME OF FATHER,

*Unknown*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W.C. Bacon*(Address) *Garret Hospital*

## 15-

JAN 12 1915

HARRY C. ANDREWS,

Filed

191

Baltimore Health Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* *11*, 1915.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 15* 1914, to *Jan 11* 1915, that I saw him alive on *Jan 11* 1915, and that death occurred, on the date stated above, at *3 P* m. The CAUSE OF DEATH\* was as follows:*Whooping Cough*(Duration) *2* yrs., *7* mos., *1* da.

## CONTRIBUTORY (Secondary)

*Bronchopneumonia*(Duration) *8* yrs., *8* mos., *8* da.(Signed) *Walter C. Bacon**1/11/15*, 191... (Address) *Garret Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *27* mos. *27* da. In the State *Unknown* yrs. *27* mos. *27* da.Where was disease contracted, if not at place of death? *1308 N. Gilmore St*Former or usual residence *1308 N. Gilmore St*

## 19-PLACE OF BURIAL OR REMOVAL,

*Landon Park*

## DATE OF BURIAL,

*Jan 12*, 1915.

## 20-UNDERTAKER

*W.E. Hughes*

## ADDRESS

*1756 Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81824

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

C81824

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1031 WILCOX STREET,

ST. 10 WARD)

FULL NAME CHARLES B. DELAUNEY,

Residence in Baltimore: No. 1031 WILCOX STREET.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-SINGLE, Married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, July 30th, 1859. (Month) (Day) (Year)

7-AGE, 55 yrs. 6 mos. 12 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Coat presser, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Charles Delauney,

11-BIRTHPLACE OF FATHER (State or Country), France,

12-MAIDEN NAME OF MOTHER Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Delauney, wife.

(Address) 1031 Wilcox street.

15- JAN 12 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CHRONIC INTERSTITIAL NEPHRITIS.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. Frederick Hempel, M. D. (Coroner)

Jan. 11th 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore Cemetery, Jan. 13 1915

20-UNDERTAKER, ADDRESS, Stewart & Howen Co, 10820 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Penn ST. 4 WARD)

2-FULL NAME Harriette A Hazeltin

Residence in Baltimore: No. 108 Penn St.; 4 yrs. 4 mos. 4 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Mar  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH Unknown 1  
(Month) (Day) (Year)

7-AGE 45 yrs. 4 mos. 4 ds. or min.?  
If LESS than 1 day, hrs. min.?

8-OCCUPATION  
(a) Trade, profession or particular kind of work Domestic  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md

10-NAME OF FATHER H. A. Wilson

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Ellen Johnson

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Taylor

(Address) 108 Penn. St

15-JAN 12 1915

Filed 191

HARRY O. ANDREWS,  
Baptist Parish Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 9 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1914 to Jan 9 1915,  
that I saw h..... alive on Jan 8 1915,  
and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH\* was as follows:

Organic Disease  
of Heart  
Chronic Interstitial  
Nephritis (Duration) 3 yrs. 3 mos. 3 ds.

Contributory (SECONDARY) Uremic Ecstasy

(Signed) J. J. Morwood M. D.  
Jan 10 1915 [Address] 939 or 7th St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Auburn Jan 12 1915

20-UNDERTAKER ADDRESS Sh

Charles B. Jones 504 Rogers

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81826

## CERTIFICATE OF DEATH.

37 C81826

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 1425 N. VINCENT STREET, ST. 15 WARD)  
2-FULL NAME GEORGE BARBER,  
(Residence in Baltimore: No. 1425 N. VINCENT STREET. St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)  
6-DATE OF BIRTH, February 22nd, / 1884.  
(Month) (Day) (Year)

7-AGE, 30 yrs., 10 mos., 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, Wagon driver.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

PARENTS.  
10-NAME OF FATHER, James Barber,  
11-BIRTHPLACE OF FATHER (State or Country), Maryland,  
12-MAIDEN NAME OF MOTHER, Sallie Bell,  
13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Elizabeth Barber,  
(Address) 2205 Division street.

15- JAN 12 1915  
Filed, HARRY C. ANDREWS, Registrar.  
Barial Forbit Clerk.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9th, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

RUPTURE OF ANEURISM OF THE ABDOMINAL AORTA,

(Duration) yrs. mos. ds.

CONTRIBUTORY LUES,  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Hempel, M. D.  
(Coroner.)

Jan. 9 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Woburn Jan 13 1915

20-UNDERTAKER ADDRESS

James H. Dennis / 303 B...



C81827 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE (No. 1924 N. BRUNT STREET,

ST. 14 WARD)

2-FULL NAME ALEXANDER EASTER,

Residence in Baltimore: No. 1924 N. BRUNT STREET.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 21 years, ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Could not ascertain, / (Month) (Day) (Year)

7-AGE, 55 yrs. ? mos. ? ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Day laborer, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Brook Easter,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Margaret Tasker,

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Solomon Easter, brother,

(Address) 1363 Woodyear street.

15-

Filed JAN 12 1915.

HARRY C. ANDREWS, Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

FRACTURED SKULL, CAUSED BY AN ACCIDENTAL FALL INTO AN ARCAWAY. (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Signed) Frederick K. M. D. (Coroner) Jan. 12, 1915 (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81828

## CERTIFICATE OF DEATH.

89 C81828

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1520 Fort Ave* ST. *24th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1520 Fort Ave* St. *8* yrs. *8* mos. *19* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE,

*white*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)*Single*

## 6-DATE OF BIRTH

*April 3, 1915*  
(Month) (Day) (Year)

## 7-AGE,

*8* yrs. *8* mos. *19* ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,  
(State or Country),*Baltimore*

## 10-NAME OF FATHER,

*John G. Lang*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Baltimore*

## 12-MAIDEN NAME OF MOTHER

*Elizabeth Little*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Mass  
S. Doherty*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Filed.....

JAN 12 1916

191.....

Serial Permit

## 16-DATE OF DEATH,

.....

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*1-1-1915*, to *1-11-1915*,that I saw her alive on *1-11-1915*,and that death occurred, on the date stated above, at *3.30 a. m.*

The CAUSE OF DEATH\* was as follows:

*Capillary Bronchitis*

(Duration).....

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(Duration).....

yrs.

mos.

ds.

(Signed).....

*L. P. Gross, M. D.**1-11-1915* (Address) *1520 Fort Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Schwartz**Jan 13, 1916*

## 20-UNDERTAKER

## ADDRESS

*J. F. McConley**39 E. Fort Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81829

HEALTH DEPARTMENT—CITY OF BALTIMORE

81829

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1844 Talbrook Ave ST. 15 WARD)

2-FULL NAME

Thomas F. Seibold

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1844 Talbrook Ave St. - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

single

6-DATE OF BIRTH

Aug 4

1906

7-AGE

8

5 mos. 7

If LESS than  
1 day, hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE  
(State or country)

Mo

10-NAME OF FATHER

Charles F. Seibold

11-BIRTHPLACE OF FATHER  
(State or country)

Mo

12-MAIDEN NAME OF MOTHER

Helen Fairley

13-BIRTHPLACE OF MOTHER  
(State or country)

Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles F. Seibold

(Address)

1844 Talbrook Ave

JAN 12 1915

HARRY O. ANDREWS,  
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan. 12, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Dec 11, 1914, to Jan 12, 1915,

that I saw him alive on Jan 12, 1915,

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH\* was as follows:

Seasickness

Contributory (SECONDARY) (Duration) yrs. mos. ds. 30

Acute Anger der. & dropy

(Signed) E. A. Smith M. D.

Jan 12, 1915 (Address) 1604 N. North Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenmount Cemetery Jan 13, 1915

20-UNDERTAKER ADDRESS

Wm. H. Hays & Co. 605 Lafayette St.

C81830

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81830

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1900 Ellwood Place ST. 8 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1900 Ellwood Place

## REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 12 mos. 12 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

## 5-SINGLE

Married  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH.

Jan 21 1871  
(Month) (Day) (Year)

## 7-AGE.

43 yrs. 11 mos. 20 ds. If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

JAN 12 1915

HARRY C. ANDREWS,

Filed....., 191..... Serial Permit Clerk Registrar.

## CORONER'S CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 10 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquest  
(Inquest, autopsy or inquiry.)and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease  
(Duration).....yrs.....mos.....ds.CONTRIBUTORY  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Elizabeth Russell M. D.(Coroner.) Jan 11, 1915 (Address) 1723 N Broadway

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

## Former or usual residence.....

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Baltimore County Jan 13, 1915

## 20-UNDERTAKER

ADDRESS 1739Fiskler & FisklerE. Eager

NOTE: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81831

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST.* 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *914 E. Fayette* St.; yrs. mos. *13* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

*Single*

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

## 6-DATE OF BIRTH,

*Dec.**31**1914*

(Month)

(Day)

(Year)

## 7-AGE,

*13*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Ind.*

## 10-NAME OF FATHER,

*Israel Rosenstein*11-BIRTHPLACE OF FATHER  
(State or Country),*Russia*

## 12-MAIDEN NAME OF MOTHER

*Hattie Simonet*13-BIRTHPLACE OF MOTHER  
(State or Country),*Russia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Israel Rosenstein*(Address) *914 E. Fayette*

## 15-

JAN 12 1915

FILED

101

HARRY C. ANDREWS,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January**12*, *1915*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec. 31, 1914*, to *Jan. 12, 1915*.that I saw her alive on *Jan. 12, 1915*,and that death occurred, on the date stated above, at *8:00 AM*.

The CAUSE OF DEATH\* was as follows:

*Gastro-enteritis*

(Duration) yrs. mos. ds.

CONTRIBUTORY Prematurity

(Secondary)

(Signed) *E. D. Glass* M. D.*Jan. 12, 1915* (Address) *J. H. H.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Hebrew Rodak Cemetery*

## DATE OF BURIAL,

*Jan. 12, 1915*

## 20-UNDERTAKER

*J. L. Lumsden*

## ADDRESS

*1107 E. Balto. St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *212 N. Madiera*ST. *6*

WARD)

REGISTERED NO. C

2-FULL NAME

*Lucmila Lupinek*(Residence in Baltimore: No. *212 N. Madiera*St. *Lifetime*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*Nov. 9, 1895*

(Month)

(Day)

(Year)

7-AGE,

*19**2*yrs. *2* mos. .... ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession or particular kind of work... *At Home*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Laundry Mechanic*

9-BIRTHPLACE, (State or Country),

*Baltimore Md.*

10-NAME OF FATHER,

*Joseph Lupinek*

11-BIRTHPLACE OF FATHER (State or Country),

*Poland*

12-MAIDEN NAME OF MOTHER

*Anna Slifka*

13-BIRTHPLACE OF MOTHER (State or Country),

*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Lupinek*(Address) *212 N. Madiera*

15-

Filed

*JAN 13 1915*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 10, 1915*

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*November 19, 1914* to *Jan 10, 1915*that I saw him alive on *Jan 10, 1915*and that death occurred, on the date stated above, at *8 a* m.

The CAUSE OF DEATH\* was as follows:

*Acute tuberculosis*  
*Pulmonary* (Duration) *2* yrs. *2* mos. .... ds.*Chronic Pneumonia*  
CONTRIBUTORY (Secondary) (Duration) *2* yrs. *2* mos. .... ds.(Signature) *W. A. Meyer* M. D.*Jan 11, 1915* (Address) *1031 N. Pauling*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Holy Redeemer*

DATE OF BURIAL,

*Jan 13, 1915*

20-UNDERTAKER

*Frank Grach Son*

ADDRESS

*W. H. Grach*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *159 W. Lanvale* ST.; *11<sup>th</sup>* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *159 W. Lanvale St.* St.; ..... yrs., ..... mos. *21* ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*5-STATUS,  
MARRIED, *Married*  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

*December 24, 1845*  
(Month) (Day) (Year)

## 7-AGE,

*69* yrs. .... mos. *18* ds.

If LESS than 1 day,

... hrs. or ... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Housewife*  
*Lady*9-BIRTHPLACE,  
(State or Country),*Austria*

## 10-NAME OF FATHER,

*Frank von Dorsner*11-BIRTHPLACE OF FATHER  
(State or Country),*Austria*

## 12-MAIDEN NAME OF MOTHER

*Marie von Kotz*13-BIRTHPLACE OF MOTHER  
(State or Country),*Bohemia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jesse Slingsluff*(Address) *2915 N. Calvert St. Balt.*

15-JAN 12 1915

HARRY O. ANDREWS,

Filed..... 191... Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 12, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*1899 Jan 1910* to *January 12 1915*that I saw him alive on *January 12 1915*and that death occurred, on the date stated above, at *8 17* m.

## The CAUSE OF DEATH\* was as follows:

*Paralytic Cerebral Clots*  
*Embolism*(Duration) *1* yrs. .... mos. .... ds.

## CONTRIBUTORY

(Secondary)

(Duration) *1* yrs. .... mos. .... ds.(Signed) *M. C. Spence* M. D......, 191... (Address) *9 E Chase St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Greenmount Cem*

## DATE OF BURIAL,

*1-13, 1915*

## 20-UNDERTAKER

*Henry W. Jenkins*

## ADDRESS

*Orchard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81834

## CERTIFICATE OF DEATH.

C81834

1-PLACE OF DEATH

1426 Montpelier St.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Eliz. Shannon

(Residence in Baltimore: No.

1426 Montpelier St.

St.;

yrs.,

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH.

May 31

(Month)

(Day)

(Year)

7-AGE

34

yrs.

mos.

ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country).

Baltimore, Md.

10-NAME OF FATHER,

Wm M Goddard

11-BIRTHPLACE OF FATHER  
(State or Country).

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Baltimore, Md.

13-BIRTHPLACE OF MOTHER  
(State or Country).

Chesapeake, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles S. Shannon

(Address)

1426 Montpelier St.

15 JAN 12 1915

ROBERT A. KRASNER,

Marital Permit Clerk.

Filed....., 191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Jan 11, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1915, to Jan 11, 1915,

that I saw her alive on Jan 10, 1915,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Congestive Heart Failure

(Duration) 2 yrs. 11 mos. 11 ds.

CONTRIBUTORY  
(Secondary)

(Duration) 1 yr. 11 mos. 11 ds.

(Signed) J. M. S. K. M. D.

Jan 11, 1915. (Address) 1426 Montpelier St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Loudon Park

Jan 14, 1915.

20-UNDERTAKER

ADDRESS

Roth &amp; Turner

1442 1/2 Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81835

## CERTIFICATE OF DEATH.

79 C81835  
REGISTERED NO. C

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *9* WARD)FULL NAME *Sadie Schlein*(Residence in Baltimore: No. *1511 Enson Street*

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *April 4, 1915*  
(Month) (Day) (Year)

7-AGE, *25* yrs. mos. ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Francis J. Rusier*  
11-BIRTHPLACE OF FATHER (State or Country), *Balto Md.*  
12-MAIDEN NAME OF MOTHER *Martha Rusier*  
13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edu L. Schlein*(Address) *1511 Enson Street*

15-*ROBERT E. KRATTS,*  
*Marial Permit Clerk.*  
JAN 12 1915  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 9, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 7 1915*, to *Jan 9 1915*, that I saw her alive on *Jan 9 1915*, and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*  
(Duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Hemiplegia*

(Signed) *J. R. Graghty* M. D.  
*Jan 9, 1915* (Address) *St Joseph's Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In the State *25* yrs. mos. ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence *1511 Enson St*

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Cnd* DATE OF BURIAL, *Jan 12, 1915*

20-UNDERTAKER *Robt J Turner* ADDRESS *1448 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81836

HEALTH DEPARTMENT—CITY OF BALTIMORE

172 C81836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Md Hosp* ST. *70* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2006 W Fayette*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *50* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*male*

4-COLOR OR RACE,

*white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Widowed*

6-DATE OF BIRTH,

*Unknown, 1*  
(Month) (Day) (Year)

7-AGE,

*73* yrs. mos. ds.

IF LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Glass Worker*

9-BIRTHPLACE,

(State or Country),

*Germany*

10-NAME OF FATHER,

*Godfrey Houck*

11-BIRTHPLACE OF FATHER,

(State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER,

*Charlotte Berch*

13-BIRTHPLACE OF MOTHER,

(State or Country),

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm Z. Summerman*

(Address) *2006 W Fayette*

15-

JAN 12 1915

Filed

ROBERT J. KRAUTER

Municipal Health Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June 11, 1915*  
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Unrestrained*

CONTRIBUTORY (Secondary)

(Signed) *J. J. Jeffers*

Coroner.

Jan 11, 1915

(Address) *113 N. Carroll*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2006 W Fayette*

19-PLACE OF BURIAL OR REMOVAL,

*Glassboro, N. J.*

DATE OF BURIAL,

JAN 13 1915

20-UNDERTAKER

*Geo. A. Gerbig*

ADDRESS

*Balducci*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

081837

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 713 N. Kenwood Av., ST. 1 WARD)

2-FULL NAME Edward Bittner

(Residence in Baltimore: No. 713 N. Kenwood Av., St. 1 yrs. 15 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, 13 hrs.,  
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JAN 12 1915

ROBERT KRAUTH,

Marital Permit Clerk,

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH\* was as follows:

Premature Labour,

Contributory  
(SECONDARY)

(Signed)

Jan 12 1915 [Address] 1528 E. Monument St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

96

C81838

PLACE OF DEATH

CITY OF BALTIMORE (No. 118 S. 7th St)

ST. 3

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Jennie Langan

(Residence in Baltimore: No. 118 S. 7th St)

St.: yrs. 55 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, Widowed, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

May

1, 1855

7-AGE,

59

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework  
At home

9-BIRTHPLACE,  
(State or Country),

Ireland

10-NAME OF FATHER,

Michael Finney

11-BIRTHPLACE OF FATHER  
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Naughton

13-BIRTHPLACE OF MOTHER  
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Langan

(Address) No. 118 S. 7th St

JAN 12 1915

ROBERT KRAUTH

Filed 191

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January

11, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Bronchial asthma

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. da.

(Signed)

David W. Jones

(Coroner)

Jan 12, 1915 (Address) 1316 Adomell St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Park

Jan 14, 1915

20-UNDERTAKER

ADDRESS

Chas. T. Evans & Son 118 W. Mt Royal Ave.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81839

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81839

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2213 N. North Ave* ST.; *15* WARD)FULL NAME *Lena White*(Residence in Baltimore: No. *2213 N. North Ave* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Female*

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

*July 13, 1855*  
(Month) (Day) (Year)

7-AGE.

*60* yrs. .... mos. .... ds.

If LESS than 1 day,

.... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Home*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Germany*10-NAME OF FATHER, *Eli Giniak*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Hinteron*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. White*(Address) *2213 N. North Ave*

15-

JAN 12 1915

ROBERT J. KRAUTER,

Filed..... 191

Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*July 11, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Nov 21, 1914, to July 11, 1915.*that I saw her alive on *July 11, 1915,*and that death occurred, on the date stated above, at *8:30 p. m.*

The CAUSE OF DEATH\* was as follows:

*Interstitial Nephritis*(Duration) *6* yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs. .... mos. .... ds.(Signed) *H. C. Peltelin* M. D.*July 12, 1915.* (Address) *347 W. Preston St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. .... mos. .... ds. In the State *1* yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Baldwin*

DATE OF BURIAL,

*July 12, 1915.*

20-UNDERTAKER

*David Dondheim*

ADDRESS

*114 W. 4th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81840

## CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *2716 Edmondson Ave* ST. *16* WARD)

FULL NAME

*Sarah Young*  
*2716 Edmondson Ave.*

Residence in Baltimore: No.

St. *55* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

SEX

*F.*

COLOR OR RACE

*W.*

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

*Widowed*

DATE OF BIRTH

*March - 23, 1837*  
(Month) (Day) (Year)

AGE

*77* yrs. *9* mos. *19* ds. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*None*

BIRTHPLACE (State or country)

*Prinl George Co. Md.*

NAME OF FATHER

*Wm P. Hall*

BIRTHPLACE OF FATHER (State or country)

*Md.*

MAIDEN NAME OF MOTHER

*Harriett P. Hall*

BIRTHPLACE OF MOTHER (State or country)

*Md.*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John H. Young*

(Address)

*2716 Edmondson Ave*

15.

*JAN 12 1915*

*ROBERT E. KRAUTER,*

*Burial Permit Clerk*

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

*Jan. - 11 - 1915*  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*Jan - 8 - 1915* to *Jan - 11 - 1915*

that I saw *W* alive on *Jan - 11 - 1915*

and that death occurred, on the date stated above, at *11:50 P. M.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia (lobar)*

(Duration) *0* yrs. *0* mos. *5* ds

Contributory (SECONDARY)

(Duration) *0* yrs. *0* mos. *5* ds.

(Signed)

*William P. Swales* M. D.  
*Jan 12, 1915* (Address) *647 N. Calhoun*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Linden Park*

*Jan 14, 1915*

20-UNDERTAKER

*Joseph A. Cook*

ADDRESS

*1003 N. Balto St.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81841

## CERTIFICATE OF DEATH.

151 C81841

REGISTERED NO. C

1-PLACE OF DEATH

Maryland General Hosp

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edwin Maurice Pepper

(Residence in Baltimore: No. 3432 Park Heights Ave.

St.;

yrs.,

mos.

12 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)  
Infant

6-DATE OF BIRTH,

Dec.

31,

1914

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. 13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Infant

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Joseph H. Tephner

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Hull M. Beret

13-BIRTHPLACE OF MOTHER (State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph H. Tephner

(Address)

3432 Park Heights Ave.

15-

JAN 12 1915

ROBERT E. KRAUTH,

Filed

191

Special Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan.

12,

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec. 31, 1914, to Jan. 12, 1915,

that I saw him alive on Jan. 12, 1915,

and that death occurred, on the date stated above, at 4:34 P.m.

The CAUSE OF DEATH\* was as follows:

Institution

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY. Asphyxia

(Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) Jos. L. Lomas M. D.

Jan. 12, 1915. (Address) Md. General Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or

usual residence 3432 Park Heights Ave.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem.

Jan. 14, 1915.

20-UNDERTAKER

ADDRESS

J. B. Clark

1003 W. Baltimore

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *94* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bertha O'Hale*(Residence in Baltimore: No. *Parkton Md.* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Unknown*, 1896

(Month)

(Day)

(Year)

7-AGE, *29*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Elijah O'Hale*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *De Wheeler*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elijah O'Hale*(Address) *Parkton Md.*

15-

HARRY O. ANDREWS,

Filed

1915

Special Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 12*, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 7*, 1915, to *Jan 12*, 1915, that I saw her alive on *Jan 12*, 1915, and that death occurred, on the date stated above, at *10:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dehiscence*  
*Post-operative*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Hypertension*

(Duration) yrs. mos. ds.

(Signed) *Henry H. Henshaw*, M. D.*Jan 12*, 1915. (Address) *University Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Parkton Md.*19-PLACE OF BURIAL OR REMOVAL, *Parkton Md.*DATE OF BURIAL, *Jan 13*, 1915.20-UNDERTAKER *E. L. Roy Stipple*ADDRESS *844 W 36th*

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

C81843

## HEALTH DEPARTMENT—CITY OF BALTIMORE

92 C81843

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ....)

2-FULL NAME

Residence in Baltimore: No. ....

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed .....

JAN 13 1915

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from 1/6/1915 to 1/11/1915, that I saw him alive on 1/4/1915 (5 P. M.) and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Lobar)  
Pneumonia (Duration) .. yrs. ... mos. ... 2 ds.

CONTRIBUTORY (Secondary)

(Signed) J. S. French M. D.  
1/12/1915 (Address) 271-22nd St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. ... mos. ... ds. In the State yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Greenmount  
J. E. Hughes 17 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *1431 E. Lombard*)

FULL NAME *Urbis Stamm*

Residence in Baltimore: No. *1431 E. Lombard*

ST. *3* WARD

REGISTERED NO. *6*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *50* yrs. *—* mos. *—* ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*  
(Write the word)

6 DATE OF BIRTH *April 2, 1939*  
(Month) (Day) (Year)

7 AGE *75* yrs. *9* mos. *10* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Germany*

10 NAME OF FATHER *Not Known*

11 BIRTHPLACE OF FATHER (State or country) *Not Known*

12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (State or country) *Not Known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs C. Simmons*

(Address) *1430 E. Chester St*

15 JAN 13 1915

BARRY O. RICHARDSON  
Burial Permit Clerk  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *January 12th 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *January 8th, 1915* to *January 12th 1915*, that I saw *her* alive on *January 12th 1915*, and that death occurred, on the date stated above, at *8:30 P. m.* The CAUSE OF DEATH\* was as follows:

*Cerebral Sclerosis and*  
*Arterio-sclerosis*  
(Duration) *2* yrs. *—* mos. *—* ds.

Contributory (SECONDARY) *—*  
(Duration) yrs. mos. ds.

(Signed) *Albert E. Singmaster* M. D.  
*Jan. 12th 1915* (Address) *1803 E. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Trinity Cem Jan 15, 1915*

20 UNDERTAKER ADDRESS  
*Peter Brodus 2026 Eastern*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

81845

81845

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 743 W. Fayette St.)

ST.

WARD

2 FULL NAME

Residence in Baltimore: No.

Str. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JAN 13 1915

Filed

191

HARRY O. ANDREWS  
Burial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81846

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

92

C81846

### PLACE OF DEATH

CITY OF BALTIMORE (No. 837 Clifford

St. 4

WARD)

### 2-FULL NAME

Thomas Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 600 (Block) Sarah Ann

St.; yrs. — mon. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

#### 3-SEX

Male

#### 4-COLOR OR RACE

Colored

#### 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

#### 6-DATE OF BIRTH,

Unknown, 1853  
(Month) (Day) (Year)

#### 7-AGE,

62 yrs. — mon. — ds.

#### IF LESS than 1 day,

hrs. or min.?

#### 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

#### 9-BIRTHPLACE,

(State or Country),

Va

#### 10-NAME OF FATHER,

Unknown

#### 11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

#### 12-MAIDEN NAME OF MOTHER

Unknown

#### 13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bertha Smith

(Address)

837 Clifford St

#### 15-

JAN 13 1915

HARRY O. ANDREWS,

Filed

101

Serial Permit Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

#### 16-DATE OF DEATH,

Jan. 9<sup>th</sup>, 1915  
(Month) (Day) (Year)

#### 17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Pneumonia Labor

(Duration) yrs. — mon. — ds.

#### CONTRIBUTORY (Secondary)

(Duration) yrs. — mon. — ds.

(Signed)

Samuel H. Smith, M. D.

(Coroner)

Jan 10<sup>th</sup>, 1915 (Address) 2302 Madison Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. — mon. — ds. In the State, yrs. — mon. — ds.

Where was disease contracted, if not at place of death?

#### Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL,

#### DATE OF BURIAL,

Int Auburn St

Jan 13, 1915

#### 20-UNDERTAKER

#### ADDRESS

La Brown & Son

108 W. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81847

C81847

## CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. *2000 N Charles* ST. *1* WARD)  
FULL NAME *John W. Brown*  
(Residence in Baltimore: No. *3403 Barclay St.* St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*  
6-DATE OF BIRTH, *Jan - Nov, 1874*  
(Month) (Day) (Year)

7-AGE, *40* yrs. mos. ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Janitor*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Haziah Brown*

11-BIRTHPLACE OF FATHER (State or Country), *Ms.*

12-MAIDEN NAME OF MOTHER *Mary J. Fowler*

13-BIRTHPLACE OF MOTHER (State or Country), *Ms.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Samuel Brown*  
(Address) *3403 Barclay St.*

15- *JAN 13 1915* HARRY O. ANDREWS,  
Filed, 191. *Barclay Permit Clerk* Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 11, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said *Inquest*, I find that said deceased came to death *on the day stated above* (Inquest, autopsy or inquiry.)

THE CAUSE OF DEATH was as follows:

*Germ warfare from stomach*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Chronic Ulcer*  
(Duration) .... yrs. .... mos. .... ds.

(Signed) *Harry O. Andrews* M. D. (Coroner)  
*Jan 14, 1915* (Address) *3640 Robinson*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Mt. Airberg* DATE OF BURIAL, *Jan 14, 1915*

20-UNDERTAKER *Samuel P. Thompson* ADDRESS *578 W. Reddle*



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81848

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81848

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1331 Hull*)

ST. *24* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME *Jatherine Mehren*

(Residence in Baltimore: No. *1331 Hull St.*)

Str. *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*  
(Write the word)

16-DATE OF DEATH *January 11, 1915*

(Month) (Day) (Year)

6-DATE OF BIRTH *July 26, 1851*

(Month) (Day) (Year)

7-AGE *63* yrs. *5* mos. *10* ds.

If LESS than 1 day, *—* hrs. or *—* min.?

17. I HEREBY CERTIFY, That I attended deceased from *Dec 26, 1914* to *Jan 11, 1915*.

that I saw her alive on *Jan 11, 1915*.

and that death occurred, on the date stated above, at *1:30* p. m.

The CAUSE OF DEATH\* was as follows:

*Suppurated fracture of the neck of the right femur, result of fall on ice*

(Duration) *—* yrs. *16* mos. *—* ds.

Contributory (SECONDARY) *Hypertensive disease*

(Duration) *—* yrs. *5* mos. *—* ds.

(Signed) *Barry O. Andrews* M. D.

*Jan 12, 1915* (Address) *1408 7th Ave. S. E.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral Cemetery*

DATE OF BURIAL *Jan 14, 1915*

UNDERTAKER

ADDRESS

*Prof. Talley & Son 1318 Light St.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Mehren*

(Address) *1331 Hull St.*

JAN 13 1915

BARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

Filed

191

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81849

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81849

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1607 Rutland av ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob E. Daley

(Residence in Baltimore: No. 1607 Rutland av. St. 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE MARRIED Married (Write the word)

6-DATE OF BIRTH July 16 1854 (Month) (Day) (Year)

7-AGE 60 5 26 11 LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Watchman (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto

10-NAME OF FATHER Jacob Daley

11-BIRTHPLACE OF FATHER (State or country) Balto

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Daley (Address) 1607 Rutland av.

JAN 13 1915

ROBERT T. TRAULS, Barial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH January 11 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16, 1914, to, Jan 11, 1915, that I saw him alive on Jan 11, 1915, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH\* was as follows:

Cancer of Liver - Autopsy

(Duration) yrs 5 mos. ds.

Contributory (SECONDARY) none

(Duration) yrs mos. ds.

(Signed) Jm J. Watson M. D. Jan 12, 1915 [Address] 2125 St Paul

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemo Jan 15, 1915

20-UNDERTAKER

ADDRESS

Robt J. Turner 11412 N. Broadway

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81850

170 C81850

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1801 Westphal Pl.* ST.; *170* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1501 Westphal Pl.* St.; yrs., mos. da.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH

*May 17, 1914*  
(Month) (Day) (Year)

## 7-AGE

*70* yrs. mos. da. If LESS than 1 day, ....hrs. or....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Basia M. New*(Address) *1501 Westphal Pl.*

## 15-

Filed

JAN 13 1915

191

ANDREWS

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 11, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Oct 10, 1914, to Jan 10, 1915*that I saw him alive on *Jan 10, 1915*and that death occurred, on the date stated above, at *3 A m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis**Indigestion*CONTRIBUTORY (Secondary) *Acute dilatation of heart*(Signed) *R. B. Campbell, M. D.**Jan 11, 1915 (Address) 1644 S. Howard St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Edgar Hill Care*

## DATE OF BURIAL

*Jan 13, 1915*

## 20-UNDERTAKER

*Roth & Turner*

## ADDRESS

*1427 N. Bond St.*

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81851

## CERTIFICATE OF DEATH.

81

C81851

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2519 Madison Ave* ST. *13* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Juliet Fauntleroy Wight*(Residence in Baltimore: No. *2519 Madison Ave*St.; *37* yrs., *?* mos., *?* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Widow*

## 6-DATE OF BIRTH.

*November 16, 1844*  
(Month) (Day) (Year)

## 7-AGE,

*70 yrs., 1 mos., 27 ds.*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*  
*None*

## 9-BIRTHPLACE,

(State or Country),

*Virginia*

## 10-NAME OF FATHER,

*Thos. W. Fauntleroy*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Virginia*

## 12-MAIDEN NAME OF MOTHER

*Juliet Healy*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Virginia*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Miss Mary C. Wight*

(Address)

*2519 Madison Ave*

15-

Filed..... 191.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 13, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 15, 1914*, to *Jan 13, 1915*, that I saw him alive on *Jan 12, 1915*, and that death occurred, on the date stated above, at *3 4* m.

The CAUSE OF DEATH\* was as follows:

*Arteriosclerosis of*  
*Coronary Arteries*(Duration) *2 yrs. 8 mos. 0 ds.*

## CONTRIBUTORY

(Secondary)

(Duration) *1 yr. 1 mos. 1 ds.*

(Signed)

*Jan 13, 1915* (Address) *2200 E. 1st St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Richmond, Virginia*

## DATE OF BURIAL,

*Jan 15, 1915*

## 20-UNDERTAKER

*Stewart Mowen Company*

## ADDRESS

*108 W North Ave*



HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

Foot Of Webster St

ST.

WARD)

CITY OF BALTIMORE (No.

George T Gilmore Known as John Tedman

FULL NAME

Tugboat Sarah Md Dreg, Co

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown

(Month) (Day) (Year)

7-AGE,

35

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Scowman

9-BIRTHPLACE, (State or Country),

Pa

10-NAME OF FATHER,

George Gilmore

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Mary A Bean

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. L. Blake

(Address) Balto. & North

15-

Filed JAN 13 1915 ROBERT Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

18

Jan., 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above. The CAUSE OF DEATH\* was as follows:

Accidental Drowning

CONTRIBUTORY (Secondary)

(Signed) Edw. L. Blake M. D. (Coroner.)

Jan 13, 1915. (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... State... In the... Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

815-W. Lombard ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Krasaukas

(Residence in Baltimore: No.

815-W. Lombard

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word.)

Single

6-DATE OF BIRTH

Jan

(Month)

12

(Day)

1915

(Year)

7-AGE,

If LESS than 1 day.

yrs. mos. ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

Baltimore Md

10-NAME OF FATHER,

John Krasaukas

11-BIRTHPLACE OF FATHER  
(State or Country),

Russian

12-MAIDEN NAME OF MOTHER

Alma Grewer

13-BIRTHPLACE OF MOTHER  
(State or Country),

Russian

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Krasaukas

(Address) 815 W. Lombard St

15-

Filed JAN 13 1915 HARRY O. ANDREWS,

Burial Permit Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Jan

(Month)

12

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw him alive on Jan 12 1915  
and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH\* was as follows:

Congenital Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. S. Coleman M. D.

191... (Address) University City

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Jan 13, 1915

20-UNDERTAKER

John Grebliaukas 500 S. Park St

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81854

C81854

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Patterson Pl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No.

St.: 17 yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May

11878

(Month)

(Day)

(Year)

7-AGE,

36

yrs.

8

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

Bartholmew McNally

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Catherine Cox

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie McNally

(Address)

1903 Patterson Pl

15-

Filed

191

HARRY O. ANDREWS

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

11

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Nov 24 1915 to Jan 11 1915

that I saw him alive on Jan 70 1915

and that death occurred, on the date stated above, at 48 m.

The CAUSE OF DEATH\* was as follows:

Aortic Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cordial Paralysis

(Duration) yrs. mos. ds.

(Signed)

H. Powers M. D.

Jan 12, 1915 (Address) 2571 E. Drexel

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

Jan. 14., 1915

20-UNDERTAKER,

ADDRESS

E. J. Fanning 1938, E. Lafayette

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081855

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

081855

PLACE OF DEATH  
CITY OF BALTIMORE (No. *2206 Oak*)  
FULL NAME *Henry Mayo Carter*  
(Residence in Baltimore: No. *2206 Oak*)

ST.: *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *1* yrs., *1* mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*  
(Write the word.)

6-DATE OF BIRTH, *June*, *1879*  
(Month) (Day) (Year)

7-AGE, *35* yrs., *6* mos., ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Salesman*  
(b) General nature of industry, business, or establishment in which employed (or employer), *Spicers*

9-BIRTHPLACE, (State or Country), *Mo.*

10-NAME OF FATHER, *Henry Mayo Carter*

11-BIRTHPLACE OF FATHER (State or Country), *Va*

12-MAIDEN NAME OF MOTHER *Mary Kivellyn*

13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. H. M. Carter*

(Address) *2206 Oak St.*

15-FILE NO. *9161 ST. NW* 191 *HARRY C. ANDERSON* Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 13 1915*  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I am in charge of the remains described above, held as *inquest*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

*Phthisis Pulmonalis*

(Duration) *2* yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) *Harry C. Anderson* M. D.

*Jan 15, 1915* (Address) *3640 Roland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs., ... mos., ... ds. In the ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Louden Park* DATE OF BURIAL, *Jan 15, 1915*

20-UNDERTAKER, *John Cook* ADDRESS *North Leonard*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81856

C81856

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1608 E. Biddle*ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Emma Poole Flaharty*(Residence in Baltimore: No. *1608 E. Biddle*

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*

5-SINGLE

MARRIED

WIDOWED

OR SEPARATED

(Write the word.)

6-DATE OF BIRTH,

*Sept. 12<sup>th</sup>, 1914*

(Month)

(Day)

(Year)

7-AGE,

*80 yrs. 3 mos. 29 ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work. *None.*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Balto Md.*

10-NAME OF FATHER,

*James Poole*

11-BIRTHPLACE OF FATHER (State or Country),

*Not known*

12-MAIDEN NAME OF MOTHER

*Not known*

13-BIRTHPLACE OF MOTHER (State or Country),

*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Laurenzo King*(Address) *1608 E. Biddle St.*

15-

Filed

JAN 13 1915

101

HARRY O. ANDREWS  
Baltimore City  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan. 11, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 18, 1910*, to *Jan. 11, 1915*, that I saw her alive on *Jan. 11, 1915*, and that death occurred, on the date stated above, at *11:20 p.m.*

The CAUSE OF DEATH\* was as follows:

*Broncho pneumonia*(Duration) yrs. mos. ds. *16 ds.*

CONTRIBUTORY

(Secondary)

*Unacertain* (Duration) yrs. mos. ds.(Signed) *Edwin B. Fenby* M. D.*Jan. 12, 1915. (Address) 1223 N. Caroline St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Olaf's Cem.**Jan. 14, 1915*

20-UNDERTAKER

ADDRESS

*William J. Goff**1723 W. Lafayette Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *109 S Stricker*ST.: *19*

WARD)

REGISTERED NO. C

## 2-FULL NAME

*Timothy Ryan*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *109 S Stricker*

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

## 6-DATE OF BIRTH.

*June 20, 1853*  
(Month) (Day) (Year)

## 7-AGE.

*61 yrs. 6 mos. 22 ds.*

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Policeman*  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE.

(State or Country), *Ireland*

## 10-NAME OF FATHER.

*Unknown*

## 11-BIRTHPLACE OF FATHER.

(State or Country), *Ireland*

## 12-MAIDEN NAME OF MOTHER.

*Unknown*

## 13-BIRTHPLACE OF MOTHER.

(State or Country), *Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Catherine Ryan*(Address) *109 S Stricker St*

## 15-

Filed *JAN 13 1915*

HARRY O. ANDERSON,

Burial Place Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 11, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *January 10, 1914*, to *January 11, 1915*, that I saw him alive on *January 11, 1915*, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH\* was as follows:

*Malum Convulsions*(Duration) *4 hrs* yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Bright's Disease*(Duration) *1* yrs. mos. ds.(Signed) *M. D.**Jan 11, 1915* (Address) *108 N. Holliston*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

*New Cathedral*

## DATE OF BURIAL.

*Jan 13, 1915*

## 20-UNDERTAKER

*John J. Field 1200 W. Lombard*

## ADDRESS

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81858

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81858

CERTIFICATE OF DEATH.

PLACE OF DEATH *Mercy Hospital*  
CITY OF BALTIMORE (No. *19* ST. *167* WARD)  
FULL NAME *Mary L. O'Hara*  
(Residence in Baltimore: No. *228 N. Gilmer*)

REGISTERED NO. C  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
St.; yrs., *5* years ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Married</i> (Write the word)
6-DATE OF BIRTH, <i>unknown</i> , 18 <i>90</i> (Month) (Day) (Year)		
7-AGE, <i>94</i> yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE, (State or Country), <i>Maryland</i>		
PARENTS.	10-NAME OF FATHER, <i>Thomas W. Wells</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER <i>Hannah Garrison</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Mrs. O'Hara*  
(Address) *439 E 23 St*

15-  
Filed *JAN 23 1915*  
HARRY O. ANDREWS,  
Sanitary Permit Clerk  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 11th*, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:  
*Accidental Burns*  
*Ignited clothes while lighting a lamp*  
(Duration) ... yrs. ... mos. ... ds.  
*Shock*  
CONTRIBUTORY (Secondary) ...  
(Duration) ... yrs. ... mos. ... ds.  
(Signed) *Thomas M. Dunne*, M. D. (Coroner.)  
*Jan. 12, 1915* (Address) *1429 Myddison Ave*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, *Resurrection Md* DATE OF BURIAL, *Jan. 14, 1915*

20-UNDERTAKER, *Ed. Widfeld* ADDRESS *Green Mt*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81859

## CERTIFICATE OF DEATH.

170 C81859

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

## 6-DATE OF BIRTH.

## 7-AGE.

If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER.

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Filed.....

191.....

HARRY O. ANDREWS,

Baptist Parsonage, Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1915 to Jan. 11, 1915, that I saw him alive on Jan. 11, 1915, and that death occurred, on the date stated above, at 4:10 A.M.

The CAUSE OF DEATH\* was as follows:

Acute hemorrhage

(Duration).....2 mos. ....ds.

CONTRIBUTORY. Chronic nephritis with hypertension. (Duration).....2 yrs. ....7 mos. ....ds.

(Signed).....Mildred Clark, M.D.

Jan. 11, 1915. (Address).....John Hopkins Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. / ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

## 20-UNDERTAKER

## ADDRESS

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1528 Thames* ST.; *3* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1528, Thames St* St.; *5* yrs., *18* mos., *18* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## SEX

*Male*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Single*

## 6-DATE OF BIRTH,

*July**26**1914*

(Month)

(Day)

(Year)

## 7-AGE,

*5**18**ds.*

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*None*

(b) General nature of industry, business, or establishment in which employed (or employer).

*Superior*

## 9-BIRTHPLACE, (State or Country),

*Baltimore*

## 10-NAME OF FATHER,

*Stanislaw Nawrocki*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Russian Poland*

## 12-MAIDEN NAME OF MOTHER

*Frances Warych*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Russian Poland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

*Stanislaw Nawrocki*

(Address)

*1528, Thames St*

## 15-

Filed

191

HARRY O. ANDREWS,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan.**13**1915*

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 12* 1915, to *Jan 13* 1915,that I saw him alive on *Jan 12* 1915,and that death occurred, on the date stated above, at *3 a. m.*

## The CAUSE OF DEATH\* was as follows:

*Convulsions accompanied by intestinal infection*

(Duration)....yrs....mos....ds.

## CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed)

*John H. Rehberger* M. D.*Jan 13* 1915 (Address) *1709 Alabama*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Holy Cross*

## DATE OF BURIAL,

*Jan 14* 1915

## 20-UNDERTAKER

*William G. Galloway*

## ADDRESS

*168 Eastern Ave.*

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH  
CITY OF BALTIMORE (No. 2702 N. Charles ST. 17 WARD)  
FULL NAME Nicholas Bras  
(Residence in Baltimore: No. 2702 N. Charles St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male  
4-COLOR OR RACE. Colored  
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single  
6-DATE OF BIRTH. Jan 12, 1915  
7-AGE. 37 mos. ds. If LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Cook.  
(b) General nature of industry, business, or establishment in which employed (or employer).  
9-BIRTHPLACE. (State or Country).  
10-NAME OF FATHER. Don't know  
11-BIRTHPLACE OF FATHER. " "  
12-MAIDEN NAME OF MOTHER. " "  
13-BIRTHPLACE OF MOTHER. " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Thomas Marshall

15-DATE OF DEATH. Jan 13 1915  
16-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery  
17-DATE OF BURIAL. Jan 13, 1915  
18-ADDRESS. 117  
19-UNDERTAKER. John A. Bishop  
20-REGISTRAR. Harry Marshall

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 12, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Whereon and from the evidence obtained by said Inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.  
The CAUSE OF DEATH was as follows:

Contributory (Secondary) Cause of Death: ...  
(Signed) Harry Marshall  
(Coroner)  
Jan 12, 1915 (Address) 117

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death. ... yrs. ... mos. ... ds. In the State. ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery  
20-DATE OF BURIAL. Jan 13, 1915

18-ADDRESS. 117

19-UNDERTAKER. John A. Bishop  
20-REGISTRAR. Harry Marshall

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81862

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N Kenwood Ave St. 120 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1010 N Kenwood Ave St.; - yrs., - mos., - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

## 5-SINGLE,

MarriedWidowedOR DIVORCED,(Write the word.)

## 6-DATE OF BIRTH

Don't know

(Month)

(Day)

(Year)

## 7-AGE

75

yrs. .... mos. .... ds.

## If LESS than 1 day,

.... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

## 9-BIRTHPLACE, (State or Country),

Ireland

## 10-NAME OF FATHER,

Don't know

## 11-BIRTHPLACE OF FATHER (State or Country),

Ireland

## 12-MAIDEN NAME OF MOTHER

Don't know

## 13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John Brady  
1010 N Kenwood Ave

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 9 1915, to Jan 11 1915,that I saw her alive on Jan 11 1915,and that death occurred, on the date stated above, at 6 A. m.

## The CAUSE OF DEATH\* was as follows:

Asphyxia fromCapillary Bronchitis

(Duration) .... yrs. .... mos. .... ds.

## CONTRIBUTORY

Chronic Intestinalneuropathy

(Duration) .... yrs. .... mos. .... ds.

(Signed) Dr. J. J. Moran

M. D.

Jan 12, 1915. (Address) 1010 N Kenwood Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

## DATE OF BURIAL,

Jan 14, 1915

## 20-UNDERTAKER

John A Moran

## ADDRESS

Bank & Ann St

## 15-

Filed

JAN 13 1915

191

HARRY O. ANSELMO,

Marial Permit Clerk

Registrar.



C81863

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81863

## CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 E Lombard St.)

FULL NAME Alice Keating

(Residence in Baltimore: No. 1721 E Lombard St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word) Married

6-DATE OF BIRTH

November 8, 1887

7-AGE

58 yrs. - mos. - ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

House Worker

9-BIRTHPLACE  
(State or country)

Ireland

10-NAME OF FATHER

James Bellie

11-BIRTHPLACE OF FATHER  
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Horror Mannin

13-BIRTHPLACE OF MOTHER  
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John M. Murphy  
1721 E Lombard

JAN 13 1915

Filed 191

HARRY O. ANDREWS,  
Burial Permit Clerk,  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

1 - 12 - 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1 - 11 - 1915, to, 1915,

that I saw her alive on 1 - 11 - 1915, and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

J. E. Salis, M. D.  
1 - 12 - 1915 [Address] 111 S. B. Quay

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Ceme.

January 15, 1915

20-UNDERTAKER

ADDRESS

Wendell S. Safford &amp; Son 37 E. Lombard St.



C81864

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81864

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2125 M<sup>e</sup> Henry* ST. *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Ada M. Haren*(Residence in Baltimore: No. *2125 M<sup>e</sup> Henry* St.; — yrs., *2* mos. *22* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

*October 19<sup>th</sup>*, *1914*  
(Month) (Day) (Year)

7-AGE,

*2* yrs., *2* mos., *22* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*none*  
*none*

9-BIRTHPLACE, (State or Country),

*Balt City*

PARENTS.

10-NAME OF FATHER,

*Larry Haren*

11-BIRTHPLACE OF FATHER (State or Country),

*Balt City*

12-MAIDEN NAME OF MOTHER

*Ada Schack*

13-BIRTHPLACE OF MOTHER (State or Country),

*Balt City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Larry Haren*(Address) *2125 M<sup>e</sup> Henry St*

15-

Filed

*JAN 13 1915**W. O. ANDREWS,*  
*Registrar.*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 11<sup>th</sup>*, *1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*January 9<sup>th</sup> 1915* to *January 11<sup>th</sup> 1915*  
that I saw her alive on *January 11<sup>th</sup> 1915*  
and that death occurred, on the date stated above, at *7:40 P. m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*  
(Duration) *5* yrs., *5* mos., *5* ds.

CONTRIBUTORY (Secondary)

(Signed) *J. H. Sullivan* M. D.  
*Jan 12<sup>th</sup> 1915* (Address) *1721 N. Fulton Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs., *2* mos., *22* ds. In the State *2* yrs., *2* mos., *22* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*London Park*

DATE OF BURIAL,

*Jan. 13, 1915*

20-UNDERTAKER

*L. L. Schwab & Bro* ADDRESS *2101 Bkch. Ave.*

important. See instructions on back of certificate.

C81865

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1423 Park Ave.* ST. *14* WARD)2-FULL NAME *Charlesetta Montague Montell*Residence in Baltimore: No. *1423 Park Ave.*St.: *77* yrs., *?* mos., *?* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If write the word.) *Single*6-DATE OF BIRTH, *June 6, 1838*  
(Month) (Day) (Year)7-AGE, *76* yrs., *7* mos., *7* ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *none*  
(b) General nature of industry, business, or establishment in which employed (or employer). *none*9-BIRTHPLACE, (State or Country). *Baltimore*10-NAME OF FATHER, *Charles M. Montell*11-BIRTHPLACE OF FATHER (State or Country), *not known*12-MAIDEN NAME OF MOTHER *Mary Pausen*13-BIRTHPLACE OF MOTHER (State or Country), *not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. Maitland DuBois*(Address) *Lake Roland, Md.*15- *JAN 13 1915* HARRY O. ANDREFiled. *191*

Burial Permit 013

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *1* *13*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan., 12<sup>th</sup>* *1915*, to *Jan., 13<sup>th</sup>* *1915*, that I saw her alive on *Jan., 13* *1915*, and that death occurred, on the date stated above, at *6:30 A.M.*. The CAUSE OF DEATH\* was as follows:*Cardiac & Hemis-*  
(Duration) *5* yrs., *5* mos., *5* ds.CONTRIBUTORY *Chronic bronchitis*  
(Secondary) *Chronic bronchitis* (Duration) *1* yr., *1* mos., *1* ds.  
(Signed) *Harry O. Andre* M. D.  
*Jan., 13, 1915* (Address) *37 W. Fayette St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Thomas Co. Ball's, Md.* DATE OF BURIAL, *Jan., 15, 1915*20-UNDERTAKER *Shaw-Watson Company* ADDRESS *108 W. North Ave.*

important. See instructions on back of certificate.

C81866

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81866

## 1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2415 more ST. 12 WARD)

## 2 FULL NAME

(Residence in Baltimore: No. 2415 more more St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

male

## 4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

## 6-DATE OF BIRTH,

Unknown, 1 (Month) (Day) (Year)

## 7-AGE,

yrs. 15 mos. ds.

If LESS than 1 day, hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

House

## 9-BIRTHPLACE, (State or Country),

Baltimore Md

## 10-NAME OF FATHER,

Simon Gholson

## 11-BIRTHPLACE OF FATHER (State or Country),

Virginia

## 12-MAIDEN NAME OF MOTHER

Dolly Edmonds

## 13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Gholson

(Address) 2415 more more

## 15-

JAN 13 1915

ROBERT E. RAUTER,

Filed. 291 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 13, 1915 (Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 12 1915, to Jan 13 1915,

that I saw him alive on Jan 12 1915,

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH\* was as follows:

Bronchitis

(Duration) yrs. mos. ds. 7

## CONTRIBUTORY (Secondary)

Heart failure

(Duration) yrs. mos. ds.

(Signed) Reginald J. Tenny M. D.

Jan 13, 1915 (Address) 4142 North Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

## 20-UNDERTAKER

Felix B. Pye

## DATE OF BURIAL,

Jan 15, 1915

## ADDRESS

102 E Mulberry St.

Important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE.

C81867

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81867

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2860 W. North Ave. 15 ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria V. Knapp(Residence in Baltimore: No. 2860 W. North Ave St.: ..... yrs. .... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

Aug ..... 1 ..... 1895  
(Month) (Day) (Year)

7-AGE,

78 yrs. 4 mos. .... ds.If LESS than 1 day,  
.... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

Joseph Seimay  
Va

12-MAIDEN NAME OF MOTHER

Matilda S. West

13-BIRTHPLACE OF MOTHER (State or Country),

?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen M. Miller(Address) 2860 W. North Ave

15-

JAN 13 1915

Filed....., 191.....

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan ..... 12 ..... 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10 1915, to Jan 12 1915,that I saw her alive on Jan 12 1915,  
and that death occurred, on the date stated above, at 6:45 m.

The CAUSE OF DEATH\* was as follows:

.....

.....

.....

CONTRIBUTORY (Secondary) apoplexy

.....

(Signed) Dr. L. F. Schmitt M. D.1/13, 1915 (Address) 2042 E. North Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount CdyJan 15 1915

20-UNDERTAKER

ADDRESS

William Cook507 E. North Ave

important. See instructions on back of certificate.



C81868

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81868

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2129 Linden Ave

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Emma Coblentz Sackerman

(Residence in Baltimore: No.

2129 Linden Ave

St.:

45

yrs.,

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

Married

## 6-DATE OF BIRTH.

Dec

25

1851

(Month)

(Day)

(Year)

## 7-AGE,

63

yrs.

—

mos.

18

ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE.

(State or Country),

Germany

## 10-NAME OF FATHER,

Daniel Coblentz

## 11-BIRTHPLACE OF FATHER

(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Regina Hirsch

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Milton Sackerman

(Address).

2129 Linden Ave

JAN 13 1915

ROBERT J. ZRAUTER,

Filed.

191.

Bureau Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

Jan

12

1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Dec

1914

to

Jan

12

1915

that I saw her alive on

Jan

12

1915

and that death occurred, on the date stated above, at 108 m.

The CAUSE OF DEATH\* was as follows:

Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY  
(Secondary)

Aortic dilatation

(Duration) yrs. 1 mos. ds.

(Signed)

J. Frederick Leitz M. D.

Jan. 13, 1915.

(Address) 2040 Eutan R.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

Balt Hebrew Cems

1/14, 1915.

## 20-UNDERTAKER

## ADDRESS

David Soudheim

118 W. Mt. Royal Ave

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

081869

108

081869

### PLACE OF DEATH

CITY OF BALTIMORE (No. *1305 Marshall*)

ST. *133* (WARD)

### FULL NAME

*Mari C. Siebert*

Residence in Baltimore: No. *1305 Marshall St*

Str.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

*Single*

6-DATE OF BIRTH

*January 18th, 1896*  
(Month) (Day) (Year)

7-AGE

*18* yrs. *11* mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Button Hole Machine Operator*

9-BIRTHPLACE  
(State or country)

*Baltimore*

10-NAME OF FATHER

*Jacob Siebert*

11-BIRTHPLACE OF FATHER  
(State or country)

*Mary*

12-MAIDEN NAME OF MOTHER

*Mary Shaefer*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*George Siebert*

(Address)

*1305 Marshall St*

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan 11, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 8, 1915* to *Jan 11, 1915*

that I saw her alive on *Jan 11, 1915*

and that death occurred, on the date stated above, at *9:30* m.

The CAUSE OF DEATH\* was as follows:

*Pericarditis*

Contributory  
(SECONDARY)

*Septic Peritonitis*  
(Duration) yrs. mos. ds.

(Signed) *W. H. Hammett* M. D.

*Jan 9, 1915* (Address) *Lyts & Marry*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Catholics* *Jan 11, 1915*

20-UNDER 18

ADDRESS

*318 Light*

JAN 13 1915

ROBERT KRAUTER

Marital Permit Clerk

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81870

151 C81870

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 S. Ann*ST.: *V* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Fanny Caplan*Residence in Baltimore: No. *20 S. Ann st*St.: *2* yrs., *18* mos. *1* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX,

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*July*

(Month)

(Day)

*1913*  
(Year)

7-AGE,

*18*

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,  
(State or Country),*Maryland*

10-NAME OF FATHER,

*Samuel Caplan*11-BIRTHPLACE OF FATHER  
(State or Country),*Baltimore, Md.*

12-MAIDEN NAME OF MOTHER

*Jennie Caplan*13-BIRTHPLACE OF MOTHER  
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

*Meyer Caplan*

(Address).....

*812 E. Lombard st*15-  
JAN 13 1915

ROBERT KRAUTER

Filed..... 191... *Karol Peralt Olark*  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan.*

(Month)

*13*

(Day)

*1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan. 6, 1915, to Jan. 13, 1915,*that I saw her alive on *Jan. 13, 1915,*and that death occurred, on the date stated above, at *5.30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Marasmus*(Duration)..... yrs. *18* mos. ds.CONTRIBUTORY  
(Secondary)*hypostatic Pneumonia*(Duration)..... yrs. *2* mos. ds.

(Signed).....

*James M. Macke, M. D.**Jan. 13, 1915* (Address) *1713 E. Balto. st.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

*20 S Ann st*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Refu. Presdel Jan. 14, 1915.*

20-UNDERTAKER

ADDRESS *1107 E**S. Linsor + Bro Balto st*

CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH. (Wallbrook) 91

C81871

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Rosedale Estate ft Tenth St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Rosedale St. foot Tenth*)St.: *20* yrs. mos. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Widow*

## 6-DATE OF BIRTH,

*Unknown 1842*  
(Month) (Day) (Year)

## 7-AGE,

*73*

yrs. mos. da.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,  
(State or Country),*Canada*

## 10-NAME OF FATHER,

*Joe Fisher*

## 11-BIRTHPLACE OF FATHER,

(State or Country),

*MD.*

## 12-MAIDEN NAME OF MOTHER

*Howe*

## 13-BIRTHPLACE OF MOTHER,

(State or Country),

*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank R. Thomas*(Address) *Silver Springs, Md.*

## 15-

JAN 13 1915

Filed

191

ROBERT KRAUTER,

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 13, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 5* 1915, to *Jan 13* 1915, that I saw her alive on *Jan 13* 1915, and that death occurred, on the date stated above, at *9 P.* in.

The CAUSE OF DEATH\* was as follows:

*Bronchitis pneumonia*

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)*Cerebral hemorrhage*

(Duration) yrs. mos. da.

(Signed) *Herbert E. Jeff* M. D.*Jan 13, 1915* (Address) *3050 N. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Washington D.C.**Jan 13, 1915*

## 20-UNDERTAKER

## ADDRESS

*Wm J. Tickner & Sons**Balto.*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81872

C81872

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

113  
REGISTERED NO. CCITY OF BALTIMORE: (No. *University Hospital* WARD)FULL NAME *Mrs Sophie Kramer*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2423 Pfeister Court* St.; *40* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)6-DATE OF BIRTH, *Unknown*, 1865 (Month) (Day) (Year)7-AGE, *50* yrs., mos., da. If LESS than 1 day, .... hrs. or .... min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *House work*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country), *Germany*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Peter Michael*(Address) *2046 Eastern Ave*

15-

JAN 13 1915

ROBERT ZRAFTER

Permit Clerk Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan* 13, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 29* 1914, to *Jan 13* 1915, that I saw her alive on *Jan 13* 1915, and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH\* was as follows:

*Hyperostrophic Chinsia*  
*of Liver*(Duration) *History of 2 months previous duration*CONTRIBUTORY  
(Secondary)(Duration) *...* yrs. *...* mos. *...* da.(Signed) *B. H. Guistard* M. D.1-13, 1915. (Address) *University Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *...* mos. *16* da. In the *29* yrs. *...* mos. *...* da.Where was disease contracted, if not at place of death? *Baltimore*Former or usual residence *2423 Pfeister Court*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mount Carmel**Jan 13, 1915*

20-UNDERTAKER

ADDRESS

*Peter Michael**2046 Eastern Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of occupation, if very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

C81873

50  
REGISTERED NO. C

C81873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

September 11 - 1897  
(Month) (Day) (Year)

7-AGE

17 yrs. 3 mos. 29 ds. or min.?

If LESS than

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer  
General

9-BIRTHPLACE  
(State or country)

Baltimore, Md.

PARENTS

10-NAME OF FATHER

Samuel Smith

11-BIRTHPLACE OF FATHER  
(State or country)

Maryland.

12-MAIDEN NAME OF MOTHER

Eleanore Gibson

13-BIRTHPLACE OF MOTHER  
(State or country)

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Brown  
Md. Penitentiary  
(Address)

15-

JAN 14 1915

HARRY O. ANDREWS,  
Corial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January - 10, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

January 7, 1915, to January 10, 1915,  
that I saw him alive on January 9, 1915,  
and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH\* was as follows:

Toxemia - Diabetic Coma

Contributory  
(SECONDARY)

Diabetes Mellitus  
(Duration) yrs. mos. 2 ds.

(Signed)

William F. Schwarz, M. D.  
January 10, 1915 [Address] Md. Penitentiary.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 2 mos. 8 ds. State, yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence 1008 E. Madison St.

19-PLACE OF BURIAL OR REMOVAL

Greenwood Cemetery

DATE OF BURIAL

Jan 14, 1915

20-UNDERTAKER

Charles B. Jones

ADDRESS

504 Rogers St.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81874

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1630 Mulberry*ST.: *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Amanda C. Wyant*(Residence in Baltimore: No. *1630 N. Mulberry Str.*

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Widowed*

6-DATE OF BIRTH,

*March 10<sup>th</sup>, 1837*  
(Month) (Day) (Year)

7-AGE,

*77 yrs. 10 mos. 1 da.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country).

*District of Columbia*

10-NAME OF FATHER,

*Wm. Smith*

11-BIRTHPLACE

OF FATHER

(State or Country).

*Md.*

12-MAIDEN NAME

OF MOTHER

*Unknown*

13-BIRTHPLACE

OF MOTHER

(State or Country).

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward S. Wyant*(Address) *1630 N. Mulberry Str.*

15-

Filed

JAN 14 1915

191

HARRY O. ANDREWS  
Bureau of Health  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 11<sup>th</sup>, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 3<sup>rd</sup> 1915, to Jan 11<sup>th</sup> 1915.*that I saw her alive on *Jan 11<sup>th</sup> 1915*,and that death occurred, on the date stated above, at *8<sup>45</sup> p. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Bronchitis*

.....

..... (Duration)..... yrs..... mos..... da.

CONTRIBUTORY

(Secondary)

..... (Duration)..... yrs..... mos..... da.

(Signed) *Henry C. O'Leary**Jan 12 1915* (Address) *1202 N. Fayette Str.**Jan 12 1915* (Address) *1202 N. Fayette Str.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Landen Park**Jan 14<sup>th</sup> 1915*

20-UNDERTAKER

*E. M. Mitchell*

ADDRESS

*1202 N. Fayette Str.*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81875

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1117 Fillmore* ST. *9* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1117 Fillmore* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*female*

## 4-COLOR OR RACE,

*white*

## 5-SINGLE,

*married**divorced*

(Write the word.)

## 6-DATE OF BIRTH,

*October ?**1861*

(Month)

(Day)

(Year)

## 7-AGE,

*53**2**?*

yrs. mos. ds.

## If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,  
(State or Country),*Va*

## 10-NAME OF FATHER,

*Ben Abbott*11-BIRTHPLACE OF FATHER  
(State or Country),*Va*

## 12-MAIDEN NAME OF MOTHER

*Matilda West*13-BIRTHPLACE OF MOTHER  
(State or Country),*Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*John F. Smith*

(Address)

*1117 Fillmore*

## 15-

Filed

191

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 13*

(Month)

(Day)

*1915*

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 10 1915, to Jan 13 1915,*that I saw her alive on *Jan 13 1915,*and that death occurred, on the date stated above, at *4 A m.*

## The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *K. J. Smith* M. D.*Jan 13, 1915. (Address) 632 Yalbach av.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore*

## DATE OF BURIAL,

*Jan 13, 1915*

## 20-UNDERTAKER

*John Boar*

## ADDRESS

*507 E. N. am*

important. See instructions on back of certificate.



C81876

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81876

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ....)

ST. ....

WARD) .....

2-FULL NAME

(Residence in Baltimore: No. ....)

St.; .... yrs. 10 mon. .... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

4-COLOR OR RACE *W* 5-SINGLE *M*  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

6-DATE OF BIRTH *Unknown*  
 (Month) (Day) (Year)

7-AGE *58* If LESS than  
 1 day, .... hrs.,  
 yrs. .... mos. .... ds. or .... min.?

8-OCCUPATION  
 (a) Trade, profession or  
 particular kind of work  
 (b) General nature of industry,  
 business, or establishment in  
 which employed (or employer)

9-BIRTHPLACE  
 (State or country)

10-NAME OF  
 FATHER

11-BIRTHPLACE  
 OF FATHER  
 (State or country)

12-MAIDEN NAME  
 OF MOTHER

13-BIRTHPLACE  
 OF MOTHER  
 (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 12, 1915*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from  
*Dec 15, 1914*, to *Jan 12, 1915*,  
 that I saw h. .... alive on *Jan 11, 1915*,  
 and that death occurred, on the date stated above, at *7:30* a.m.

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhages*

Contributory (SECONDARY) *Acute*  
 (Duration) .... yrs. .... mos. .... ds.

(Signed) *J. J. Morwood* M. D.  
*Jan 12, 1915* [Address] *640 N. Broadway*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death .... yrs. .... mos. .... ds. in the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Int. Annapolis* *Jan 14, 1915*

20-UNDERTAKER

ADDRESS

*W. H. Hooper* *601 N. Broadway*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-  
 JAN 14 1915

HARRY O. ANDREWS,  
 Chief Clerk  
 REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81877

## CERTIFICATE OF DEATH.

79 C81877

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Linden Ave. ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Annie J. Whitman

(Residence in Baltimore: No. 1410 Linden Ave

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female white

## 4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
widowed

## 6-DATE OF BIRTH,

Dec. 7<sup>th</sup>, 1834.  
(Month) (Day) (Year)

## 7-AGE,

80 yrs. 1 mos. 6 ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE.  
(State or Country),

Maine

## 10-NAME OF FATHER,

Ruben Crain

11-BIRTHPLACE OF FATHER  
(State or Country),

Mass.

## 12-MAIDEN NAME OF MOTHER

Mary Tuck

13-BIRTHPLACE OF MOTHER  
(State or Country),

Mass.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward B. Mathers

(Address) 1410 Linden Ave.

JAN 14 1915

Filed..... 191..... HARRY O. ANDREWS, Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 13, 1915.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

1914, to Jan. 13, 1915.

that I saw her alive on Jan. 12, 1915,

and that death occurred, on the date stated above, at 7<sup>th</sup> m.

The CAUSE OF DEATH\* was as follows:

Myocardial

(Duration) 2 wks. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) 2 wks. 1 mos. 1 ds.

(Signed) Henry A. Brown M. D.

Jan. 14, 1915. (Address) 19 W. Biddle St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Croy N. Y.

## DATE OF BURIAL,

Jan. 15, 1915.

## 20-UNDERTAKER

C. M. Mitchell

## ADDRESS

2014 W. Fayette

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81878

## CERTIFICATE OF DEATH

C81878

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1819 Ramsey*)

ST. *19* WARD)

2-FULL NAME

*Nathaniel S. Carry*

(Residence in Baltimore: No. *above*)

St. *60* yrs. *4* mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*  
(Write the word)

6-DATE OF BIRTH *Unknown*, 1839  
(Month) (Day) (Year)

7-AGE *75* yrs. *4* mos. *7* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Carpenter*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto Co. Md.*

10-NAME OF FATHER *Henry Carry*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Sarah Ann Fowler*

13-BIRTHPLACE OF MOTHER (State or country) *Ma.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Miss Nathaniel S. Carry*

(Address) *1819 Ramsey St.*

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *1* *12*, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *1.4*, 1915, to *1.12*, 1915, that I saw him alive on *1.12*, 1915, and that death occurred, on the date stated above, at *8.00 P. m.* The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*

(Duration) .... yrs. .... mos. *8* ds.

Contributory (SECONDARY) *Age*

(Signed) *J. D. Light* M. D. *113*, 1915 (Address) *211 N. Lawrence*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Louder Park* DATE OF BURIAL *Jan 16, 1915*

20-UNDERTAKEN *Geo. B. Cook* ADDRESS *1003 N. Balto*

JAN 14 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81879 HEALTH DEPARTMENT—CITY OF BALTIMORE 28

CERTIFICATE OF DEATH.

PLACE OF DEATH ON SIDEWALK,  
CITY OF BALTIMORE (No. S.E. COR. PENNSYLVANIA AVE. & ROBERT ST.)  
FULL NAME EMANUAL FREEMAN,  
(Residence in Baltimore: No. 1916 N. BRUNT STREET.

81879  
REGISTERED No. C 81877  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
St.; yrs. 9 years, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male,	4-COLOR OR RACE, Colored,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,
6-DATE OF BIRTH, February 3d, 1889, (Month) (Day) (Year)		
7-AGE, 25 yrs. 11 mos. 8 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Ten-pin boy (b) General nature of industry, business, or establishment in which employed (or employer). in bowling alley.		
9-BIRTHPLACE, (State or Country), Virginia,		
PARENTS.	10-NAME OF FATHER, Bernard Freeman,	
	11-BIRTHPLACE OF FATHER (State or Country), Virginia,	
	12-MAIDEN NAME OF MOTHER Arabella Walker,	
	13-BIRTHPLACE OF MOTHER (State or Country), Virginia.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Charles Freeman, brother,  
(Address) 1916 N. Brunt street.

15-  
JAN 14 1915  
HARRY O. ANDREWS,  
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,  
January 11th, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
PULMONARY HAEMORRHAGE.  
(Duration) 5 minutes.  
CONTRIBUTORY PULMONARY TUBERCULOSIS, (Secondary)  
(Duration) INDEFINITE.  
(Signed) J. Frederick Hampel M. D. (Coroner.)  
Jan. 11, 1915 (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place In the  
of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted, if not at place of death?

19-Former or usual residence  
20-UNDERTAKER  
George H. Holland 517 Robert St.  
DATE OF BURIAL, Jan 14 1915  
ADDRESS



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

103

C81880

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1321 W Baltimore

ST. 19 WARD)

2-FULL NAME Ella T. Mc Carmick.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1321 W Baltimore

St. 10 yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single  
6-DATE OF BIRTH December 18, 1874 (Month) (Day) (Year)  
7-AGE 40 yrs. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Maryland

PARENTS

10-NAME OF FATHER

John M. Carmick

11-BIRTHPLACE OF FATHER (State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Margaret Donahue

13-BIRTHPLACE OF MOTHER (State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Mc Carmick

(Address) Catonsville

15-

AN 14 1915

HARRY O. ANDREWS,

Chief of Bureau, Bureau of Health

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 13, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 11, 1915, to January 13, 1915, that I saw her alive on Jan. 12, (11:30 P.M.), 1915, and that death occurred, on the date stated above, at 12:15 A.M. The CAUSE OF DEATH\* was as follows:

Acute Indigestion

Contributory (SECONDARY)

(Signed) H. Austin Delcher M. D.

Jan 13, 1915. (Address) 2250 E. Haffman St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

Jan 15, 1915

20-UNDERTAKER

ADDRESS

Joe. B. Cook

1003 N. Balto

58

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 C81881

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St Joseph Hosp* ST.: *24* WARD)

2-FULL NAME

*Thomas Goldstraw*  
(Residence in Baltimore No. *1319 Corks*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, *Married* OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)

7-AGE, *(40)* If LESS than 1 day, *X* yrs. mos. ds. .... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Shradine* (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *James Goldstraw*

11-BIRTHPLACE OF FATHER (State or Country), *England*

12-MAIDEN NAME OF MOTHER, *Kellen Martin*

13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sarah Goldstraw*  
(Address) *1319 Corks*

15- *JAN 14 1915* HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 13*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acute Nephritis*  
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *uraemia*

(Signed) *Elyah Russell* M. D. (Coroner.)

*Jan 14*, 1915 (Address) *423 N. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. .... mos. .... ds. State.... yrs. .... mos. .... ds. In the

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill* DATE OF BURIAL, *Jan 17*, 1915

20-UNDERTAKER *William Cook* ADDRESS *507 E. North*

C81882

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

170  
REGISTERED NO. C

C81882

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St Joseph's Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Maria C. Hardy

(Residence in Baltimore: No.

749 George St.

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

female

## 4-COLOR OR RACE,

negress

5-SINGLE, married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH

Unknown, 1873  
(Month) (Day) (Year)

## 7-AGE,

42

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

Somerset Co Md

## PARENTS.

## 10-NAME OF FATHER,

Mr Under

## 11-BIRTHPLACE OF FATHER

(State or Country),

Md

## 12-MAIDEN NAME OF MOTHER

Unknown

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Denton C. Hardy

(Address)

749 George St

## 15-

JAN 14 1915

HARRY O. ANDREWS,

Filed 191. Burial Permt. Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 12, 1915.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 9 1915, to Jan 12 1915,  
that I saw her alive on Jan 12 1915,

and that death occurred, on the date stated above, at 8:50 a.m.

## The CAUSE OF DEATH\* was as follows:

Chronic Nephritis,  
Mitral Insufficiency

(Duration) yrs. 5 mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. 5 mos. ds.

(Signed) D. H. Vinton, M. D.

Jan 12, 1915 (Address) St. Joseph's Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

unknown

Former or usual residence

749 George St.

## 19-PLACE OF BURIAL OR REMOVAL,

Lanier Cemetery

## DATE OF BURIAL,

## 20-UNDERTAKER

D. H. Vinton, M. D.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 Park Ave* ST.; *11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. *609 Park Ave* St.; *-* yrs., *-* mos., *-* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED, *Married*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*November 5<sup>th</sup>, 1868*  
(Month) (Day) (Year)

## 7-AGE,

*46* yrs., *2* mos., *8* ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),*Beaufort, S.C.*

## 10-NAME OF FATHER,

*Middleton S. Elliott*11-BIRTHPLACE OF FATHER  
(State or Country),*Beaufort, S.C.*

## 12-MAIDEN NAME OF MOTHER

*Ann Sarah Rhett*13-BIRTHPLACE OF MOTHER  
(State or Country),*Beaufort, S.C.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. Randolph*(Address) *609 Park Ave*

## 15-

JAN 14 1915

Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January 13, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*1913* to *Jan 13* *1915*that I saw h *4* alive on *Jan 13* *1915*and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH\* was as follows:

*Subacute lobar - granular**hepatitis*(Duration) *4* yrs., *-* mos., *-* ds.CONTRIBUTORY  
(Secondary)(Duration) *4* yrs., *-* mos., *-* ds.(Signed) *None R. Brown* M. D.*Jan 3, 1915* (Address) *19 W. Biddle St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Greenpoint Cemetery*

## DATE OF BURIAL,

*Jan 16, 1915*

## 20-UNDERTAKER

*Henry W. Jenkins & Sons Co. Orchard St.*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81884

C81884

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: No. 789 Sarah Anne

ST.:

WARD) 4

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 789 Sarah Anne

St.: 14 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE,

Colored

## 5-SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED,

(Write the word.)

## 6-DATE OF BIRTH

December 5, 1863  
(Month) (Day) (Year)

## 7-AGE,

51 yrs., 1 mos., 7 ds.

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

## 9-BIRTHPLACE,

(State or Country), Maryland

## 10-NAME OF FATHER,

John Henry Shorter

## 11-BIRTHPLACE OF FATHER

(State or Country), Maryland

## 12-MAIDEN NAME OF MOTHER

Emeline Hall

## 13-BIRTHPLACE OF MOTHER

(State or Country), Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

## 15-

JAN 14 1915

HARRY O. ANDREWS,

Corial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 12, 1915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Sept. 12 1914, to Jan. 12 1915

that I saw him alive on Jan. 12 1915

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH\* was as follows:

Acute Pulmonary Tuberculosis  
(Duration) 5 yrs., mos., ds.CONTRIBUTORY  
(Secondary)

(Duration) 5 yrs., mos., ds.

(Signed) W. H. Brown M. D.

Jan 12, 1915. (Address) 1837 Penna. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

St. Peter's Cemetery

## DATE OF BURIAL,

Jan. 15, 1915

## 20-UNDERTAKER

John H. Owens

## ADDRESS

1222 Burr

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81885

64 C81885

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *309 Dolphin* ST.: *11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Florence May Hadel*(Residence in Baltimore: No. *309 Dolphin* St.: *56* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *Feb. 17, 1*

(Month)

(Day)

(Year)

7-AGE, *56* yrs., *10* mos., *27* ds.

If LESS than 1 day, .... hrs. or .... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore Md*

## PARENTS.

10-NAME OF FATHER, *Chas. J. Hough*11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*12-MAIDEN NAME OF MOTHER *Mary A. Sumwalt*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carolina Potts*(Address) *1005-22nd St. N. W. D.C.*

15-

Filed

JAN 14 1915

191

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 12, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 12* 191*4*, to *Jan 12* 191*5*.that I saw h or alive on *Jan 12* 191*5*,and that death occurred, on the date stated above, at *10<sup>30</sup>* m.

The CAUSE OF DEATH\* was as follows:

*Cerebral hemorrhage*

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Ch. related vessels*

(Duration) .... yrs. .... mos. .... ds.

(Signed) *John B. Hough* M. D.*Jan B.*, 191*5* (Address) *1025 Madison*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount Cus. Park*DATE OF BURIAL, *Jan 16 1915*20-UNDERTAKER *John C. Hough*ADDRESS *1422*

C81886

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81886

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *James Hopkins House* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Riverton W. Va.* St.; *7* yrs. *4* mos. *13* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If write the word.) *Married*

## 6-DATE OF BIRTH,

*Aug* *30*, *1866*  
(Month) (Day) (Year)

## 7-AGE,

*48* yrs. *4* mos. *13* ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE,

(State or Country), *W. Va.*

## 10-NAME OF FATHER,

*Abraham Mallow*

## 11-BIRTHPLACE OF FATHER

(State or Country), *W. Va.*

## 12-MAIDEN NAME OF MOTHER

*Rebecca Dice*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *W. Va.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James L. Payne*(Address) *Harman W. Va.*

## 15-

JAN 14 1915

Filed....., 191.....

HARRY O. ANDERSON

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* *14*, *1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 12* *1914*, to *Jan 14* *1915*,that I saw her alive on *Jan 14* *1915*and that death occurred, on the date stated above, at *9:45* m.

The CAUSE OF DEATH\* was as follows:

*Carcinoma of ovaries*(Duration)..... yrs. *6* mos. .... ds.

## CONTRIBUTORY

(Secondary)

*as theia, surgical*  
*Shock* (Duration)..... yrs. .... mos. *2* ds.

(Signed)

*George W. Corner* M. D.  
*Jan. 14 1915* (Address) *745*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. *2* ds. In the State yrs. .... mos. *2* ds.Where was disease contracted, if not at place of death? *inensive*Former or usual residence *Riverton W. Va.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Harman W. Va.*

## DATE OF BURIAL,

*Jan. 15, 1915*

## 20-UNDERTAKER

*Albert C. Fuller*

## ADDRESS

*221 N. Broadway*

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81887

## CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9* WARD)FULL NAME *Mrs. Margaret Medinger*(Residence in Baltimore: No. *1414 N. Central av.* St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *widowed*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, *June 3, 1894*

(Month)

(Day)

(Year)

7-AGE, *70*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto and Md*10-NAME OF FATHER, *J. E. Schereth*11-BIRTHPLACE OF FATHER (State or Country), *Balto*12-MAIDEN NAME OF MOTHER, *Miss Kinn*13-BIRTHPLACE OF MOTHER (State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *J. E. Schereth*(Address), *2007 Eastern av.*

JAN 14 1915

ROBERT E. ZERSTER

Filed, 1915, Marial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 13, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 9, 1915*, to *Jan 13, 1915*,that I saw her alive on *Jan 13, 1915*,and that death occurred, on the date stated above, at *5.30 P. M.*

The CAUSE OF DEATH\* was as follows:

*Chronic Myocarditis*(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY... *Pulmonary Edema*

(Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.(Signed) *H. H. Warner* M. D.*Jan 13, 1915* (Address) *St. Joseph's Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs. *4* mos. *4* ds. State *4* yrs. *4* mos. *4* ds.Where was disease contracted, if not at place of death? *1414 N. Central av.*Former or usual residence *1414 N. Central av.*19-PLACE OF BURIAL OR REMOVAL, *St. Joseph's Hospital*DATE OF BURIAL, *Jan 16, 1915*20-UNDERTAKER, *Robt. Warner*ADDRESS, *14424 Bessy*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81888

## CERTIFICATE OF DEATH.

C81888

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. ...)

ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ellie Stalland

(Residence in Baltimore: No. ...)

1722 Christian St

St.; 26 yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Jan

(Month)

(Day)

1891  
(Year)

7-AGE,

24

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,  
(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER  
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

Lewis  
1419 E. Balto St

15-JAN 14 1915

ROBERT

ZRAUTER

Filed.....

191.....

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January

(Month)

14

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 11 1915, to Jan 14 1915,

that I saw her alive on Jan 14 1915,

and that death occurred, on the date stated above, at 8:45 Am.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency  
Mitral Stenosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY... Acute Cardiac Dilatation  
(Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) M. B. Lewis M. D.

191... (Address) Hebrew Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

At home

Former or usual residence

1722 Christian St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Washing

Jan. 15, 1915

20-UNDERTAKER

ADDRESS

Jack Lewis

1419 E. Balto St

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81889

C81889

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 17 yrs., 6 mos. 4 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single*  
(Write the word.)

6-DATE OF BIRTH, *July 9<sup>th</sup> 1897*  
(Month) (Day) (Year)

7-AGE, *17* yrs. *6* mos. *4* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Paul Henauwosh*  
(b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *Solomon Randall*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md*

12-MAIDEN NAME OF MOTHER, *Budene Randall*

13-BIRTHPLACE OF MOTHER (State or Country), *va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. R. Jackson, M.D.*

(Address) *117 N. Cassell*

15-JAN 14 1915

Filed..... 1915

ROBERT E. TRAUTMAN

Marital Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 13<sup>th</sup> 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 2<sup>nd</sup> 1915* to *Jan 12 1915*, that I saw her alive on *Jan 12 1915*, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Acute Pneumonia*

(Duration)..... yrs..... mos. *11* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *H. R. Jackson* M. D.

*1/13* 1915. (Address) *117 N. Cassell*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Asbury Cemetery Jan 15<sup>th</sup> 1915*

UNDERTAKER ADDRESS

*Chas. E. Bailey Jefferson St*

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81890

C81890

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1169 W Hamburg St

ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME Esther J G Weidemeyer

Residence in Baltimore: No. 1169 W Hamburg St

St.: 54 yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

June 7, 1860.  
(Month) (Day) (Year)

## 7-AGE,

54 yrs., 5 mos., 5 ds.

If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer).

None

9-BIRTHPLACE,  
(State or Country),

Balto Md

10-NAME OF  
FATHER,

Jesse P Allbright

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Balto Md

12-MAIDEN NAME  
OF MOTHER

Unknown

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Balto Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest M Weidemeyer

(Address) 1169 W Hamburg St

## 15-

Filed JAN 14 1915

ROBERT J. KRAUTH, M.D.

Sanitary Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 12, 1915.  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Nov. 25 1914 to Jan 12 1915,  
that I saw h or alive on Jan 11 1915,  
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Nephritis Chronic

(Duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY Uremia  
(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) E. J. Krauth M. D.

Jan 13, 1915. (Address) 517 Scott St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Mt. Olivet

Jan 15, 1915.

## 20-UNDERTAKER

## ADDRESS

Jas. Biquan, 1000 Wood Ave.

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81891

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81891

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *552 W. Hoffman* St. *17* WARD)

2-FULL NAME *Frances E. Myer*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *552 W. Hoffman* St. *50* yrs. - mos. - da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Widow*  
6-DATE OF BIRTH *Not known* - 1850  
(Month) (Day) (Year)  
7-AGE *65* yrs. - mos. - ds. or min.?

8-OCCUPATION  
(a) Trade, profession or particular kind of work *Nurse*  
(b) General nature of industry, business, or establishment in which employed (or employer) *maternity nurse*

9-BIRTHPLACE (State or country) *2. A. Co. Md.*

PARENTS  
10-NAME OF FATHER *Thos Murray*  
11-BIRTHPLACE OF FATHER (State or country) *2. A. Co. Md.*  
12-MAIDEN NAME OF MOTHER *Alice*  
13-BIRTHPLACE OF MOTHER (State or country) *2. A. Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alice M. Telford*  
(Address) *1237 Division St.*

15-  
*JAN 14 1915* ROBERT KRAUTER,  
Marial Permit Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 12*, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 7<sup>th</sup>*, 191*4*, to *Jan 12<sup>th</sup>*, 1915, that I saw her alive on *Jan 19<sup>th</sup>*, 1915, and that death occurred, on the date stated above, at *11* m. The CAUSE OF DEATH\* was as follows:

*Gastric Enteritis* (Duration) - yrs *3* mos. - ds.  
Contributory *Cardiac Weakness* (SECONDARY)  
(Signed) *Edmund E. Mackenzie* M. D.  
*Jan 13*, 1915 (Address) *1337 W. North St.*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL *Laurel Cem* DATE OF BURIAL *1/15*, 1915  
20-UNDERTAKER *Sam L. T. Hensley* ADDRESS *578 W. Beside*



C81892

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81892

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1400 Hanover* ST.; *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Barbara Koll*(Residence in Baltimore: No. *1400 Hanover* St.; *55* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

*Widow*  
(Write the word.)

## 6-DATE OF BIRTH

*February 5<sup>th</sup> 1842*  
(Month) (Day) (Year)

## 7-AGE,

*72* yrs. *4* mos. *2* ds.

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*House work*

(b) General nature of industry, business, or establishment in which employed (or employer).

*at home.*

## 9-BIRTHPLACE.

(State or Country).

*Germany.*

## 10-NAME OF FATHER,

*John Seabury*

## 11-BIRTHPLACE OF FATHER

(State or Country).

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Not known*

## 13-BIRTHPLACE OF MOTHER

(State or Country).

*Germany.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

*Nicholas Koll*

(Address).

*1317 N. Lombard St.*

## 15-

*JAN 14 1915**ROBERT E. RAUTES,*

Filed.....

101.

*Marion Permle Clerk.*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*January 12, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan. 6, 1915, to Jan. 12, 1915,*that I saw her alive on *Jan. 12, 1915,*and that death occurred, on the date stated above, at *5:30 A.M.*

## The CAUSE OF DEATH\* was as follows:

*Biliary Calculi (impacted)**Long Duration* (Duration) yrs. mos. ds. *7*

## CONTRIBUTORY (Secondary)

*Cardiac failure* (Duration) yrs. mos. ds.

(Signed)

*Robert E. Rautes* M. D.  
*Jan. 14, 1915.* (Address) *1317 N. Lombard St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Holy Redeemer**1-15, 1915*

## 20-UNPERTAKER

*E. B. Horle*

## ADDRESS

*115 E. North St.*

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81893

## CERTIFICATE OF DEATH.

79

C81893

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 14 1915

ROBERT T. TRAUTES,

Marital Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

1/14, 1915. (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306. S. Bond.

ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 306. S. Bond.

St.; yrs. mos. 10 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE

MARRIED

WIDOWED

DIVORCED

(Write the word.)

6-DATE OF BIRTH,

Jan. 4, 1915

7-AGE,

yrs. mos. 10 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 14 1915

ROBERT KRAUTER,

Marital Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1915, to Jan 14, 1915,

that I saw him alive on Jan 14, 1915,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Influenza Pneumonia

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) 1605 Bond St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Trinity

Jan 12, 1915

20-UNDERTAKER

ADDRESS

William Fiedoruk

1618 Eastern Ave.

important. See instructions on back of certificate.

C81895

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

28 C81895

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

407 S. Ann

## 2-FULL NAME

Joseph. Fibich

(Residence in Baltimore: No.

407 S. Ann

ST.: 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 23 yrs. 13 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Dec

31

1891

7-AGE,

23

13

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Musician

Band, Orchestra

9-BIRTHPLACE,  
(State or Country),

Baltimore

10-NAME OF FATHER,

Andrew. Fibich

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Rosalie Malawa

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Andrew. Fibich

(Address)

407 S. Ann St.

15-

JAN 14 1915

Filed

ROBERT T. TRAUBER

Municipal Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January

13

1915

17- I HEREBY CERTIFY, That I attended deceased from December 29 1914, to January 13 1915, that I saw him alive on January 13 1915, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis of tubercles of lungs

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthma &amp; arteriosclerosis

(Duration) yrs. 9 mos. ds.

(Signed) Henry A. Muller M. D.

Jan. 13 1915. (Address) 106 Yorkson Pl.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Jan. 16 1915

20-UNDERTAKER

William. Fialkowski

ADDRESS

1618 Eastern Ave

important. See instructions on back of certificate.



183

C81896

HEALTH DEPARTMENT--CITY OF BALTIMORE

C81896

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 803 Hillen Street St. 5 WARD)

2-FULL NAME Patrick Roddy

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 803 Hillen Street St. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED Married (Write the word)

6-DATE OF BIRTH (Month) (Day) (Year)

7-AGE About 70 yrs. mos. ds. or min. 2 If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Saloon keeper

9-BIRTHPLACE (State or country) Ireland

10-NAME OF FATHER Patrick Roddy

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Bridget Cox

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss May Roddy

(Address) 803 Hillen St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 1 13 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9<sup>th</sup>, 1915, to Jan 12<sup>th</sup>, 1915, that I saw him alive on Jan 12<sup>th</sup>, 1915, and that death occurred, on the date stated above, at 10:34 a.m.

The CAUSE OF DEATH\* was as follows: Pulmonary tuberculosis

Contributory (SECONDARY) Cal. Dis. Throat

(Signed) Edward J. Reilly M. D. Jan 14<sup>th</sup>, 1915 [Address] 208 Angell St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral Cemetery Jan 16, 1915

UNDERTAKER Henry W. Meas 805 N. Calvert St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15- JAN 14 1915 ROBERT J. KRAUTH Registrar

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081897 HEALTH DEPARTMENT--CITY OF BALTIMORE  
64081897  
CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Dmd Hill ST. 14 WARD)

2-FULL NAME Frank Asbury Dozier

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 12)

(Residence in Baltimore: No. 1622 Dmd Hill av St. 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colord 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH March 15, 1837 (Month) (Day) (Year)

7-AGE 77 yrs 9 mos 28 ds. or min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Waiter

9-BIRTHPLACE (State or country) Frederick Md.

10-NAME OF FATHER William Dozier

11-BIRTHPLACE OF FATHER (State or country) Frederick Md.

12-MAIDEN NAME OF MOTHER Rebecca Snyder

13-BIRTHPLACE OF MOTHER (State or country) Frederick Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Chester

(Address) 1622 Dmd Hill av

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH January 13, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1915, to Jan 13, 1915, that I saw him alive on Jan 12, 1915, and that death occurred, on the date stated above, at 4:45 a.m. The CAUSE OF DEATH\* was as follows:

Emphysema (Duration) yrs mos. ds. 3

Contributory (SECONDARY) Cerebral Hemorrhage (Duration) yrs mos. ds. 14 (Signed) Jm H. Toadwin M. D. Jan 13, 1915 [Address] 1204 Presden St

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos. ds. In the State yrs mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Auburn Jan 15, 1915

20-UNDERTAKER ADDRESS

John H. Toadwin 142 W Hill St

18- JAN 14 1915 ROBERT F. RAUTER, REGISTRAR

C81898

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

64 C81898

PLACE OF DEATH IN THE NORTHWESTERN AUTO EN ROUTE

CITY OF BALTIMORE (No. TO MARYLAND GENERAL HOSPITAL, 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

JAMES E. WEBB,

Residence in Baltimore: No. 1215 DRUIDHILL AVENUE.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <b>Male,</b>	4-COLOR OR RACE, <b>Colored,</b>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <b>Married,</b>
6-DATE OF BIRTH, <b>October 27th, 1876.</b> (Month) (Day) (Year)		
7-AGE, <b>38 yrs. 2 mos. 16 ds.</b>		If LESS than 1 day, ....hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <b>Waiter</b> (b) General nature of industry, business, or establishment in which employed (or employer). <b>in social club.</b>		

9-BIRTHPLACE,  
(State or Country), **Maryland,**10-NAME OF FATHER, **James webb,**11-BIRTHPLACE OF FATHER  
(State or Country), **Maryland,**12-MAIDEN NAME OF MOTHER **May Roberts,**13-BIRTHPLACE OF MOTHER  
(State or Country), **Maryland.**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Bernard Webb, brother,**(Address) **1823 McCulloh street.**

15-

ROBERT KRAUTER

Filed

JAN 14 1915

Marial Permit Clerk  
Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

**January 12th, 1915.**  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry**  
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said **inquiry** and that said deceased came to **his** death on the day stated above.  
(Inquest, au-  
topsy or inquiry.)

The CAUSE OF DEATH\* was as follows:

**CEREBRAL HAEMORRHAGE,**

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY **CHRONIC INTERSTITIAL****NEPHRITIS** (Duration) **9** mos. .... ds.(Signed) **Frederick Hempel** M. D.  
(Coroner.)Jan. 13, 1915. (Address) **1103 Valley st.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the  
of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

**St Auburn, Cn.****Jan 13, 1915**

20-UNDERTAKER

ADDRESS

**John H. Toadine 142 W. 14th St.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Church Home & Infirmary* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Florence Goner*(Residence in Baltimore: No. *243 N. Guilmo St* St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*December 13, 1877*  
(Month) (Day) (Year)

7-AGE

*37*If LESS than 1 day,  
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer).*Lordady*  
*Drug Store*9-BIRTHPLACE,  
(State or Country),*MD*

10-NAME OF FATHER,

*Robert Gover*11-BIRTHPLACE OF FATHER  
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*Sarah E. Griffin*13-BIRTHPLACE OF MOTHER  
(State or Country),*MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Robert Gover*

(Address)

*243 N. Guilmo*

15-

Filed

*JAN 14 1915*

ROBERT E. SAUTES,

Baltimore Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 14, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Jan 1* 1915, to *Jan 14* 1915,  
that I saw her alive on *Jan 13* 1915,  
and that death occurred, on the date stated above, at *4:30 AM*.  
The CAUSE OF DEATH\* was as follows:*Acute Edema of Lung*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Pelvic Peritonitis*

(Duration) yrs. mos. ds.

(Signed) *J. Davis* M. D.*Jan 14, 1915* (Address) *Church Home & Inf.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *14* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

*Unknown*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Balto cem**Jan 18, 1915*

20-UNDERTAKER

*Wm Cook*

ADDRESS

*715 N. Ave*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81900

## CERTIFICATE OF DEATH.

79 C81900  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Gorman Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1351 W. Gilman St. St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWED,

(Write the word.) Married

## 6-DATE OF BIRTH,

June6  
(Month)1882  
(Day)1882  
(Year)

## 7-AGE,

3277

If LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Labour9-BIRTHPLACE,  
(State or Country),W.S. Maryland

## 10-NAME OF FATHER,

Robert Jennings11-BIRTHPLACE OF FATHER  
(State or Country),W.S.

## 12-MAIDEN NAME OF MOTHER

Callie Rose13-BIRTHPLACE OF MOTHER  
(State or Country),W.S.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Robert Jennings

(Address)

32 Gorman

## 15-

JAN 14 1915

ROBERT KRAUTER

Filed

No.

Karl A. Peralt Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan.131915  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 7 1915, to Jan 13 1915,that I saw him alive on Jan 13 1915,and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis(Duration) 2 yrs. 6 mos. 6 da.CONTRIBUTORY  
(Secondary)As. Arterio Sclerosis(Duration) 6 yrs. 6 mos. 6 da.(Signed) E. W. Woodruff M. D.Jan 14, 1915 (Address) 24 W. Fullerton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Woodlawn Cem Jan 16, 1915

## ADDRESS

## 20-UNDERTAKER

J. M. Cook1014 E. Lombard St.

Important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081901

HEALTH DEPARTMENT—CITY OF BALTIMORE

081901

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2612 Riggs Ave ST. 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
2-FULL NAME John Laurence Hobbs  
(Residence in Baltimore: No. 3612 Riggs Ave St.; 1 yrs. 5 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Infant  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)  
6-DATE OF BIRTH Aug 22, 1913  
(Month) (Day) (Year)  
7-AGE 1 yrs. 4 mos. 23 ds. or min. If LESS than 1 day, hrs.  
8-OCCUPATION (a) Trade, profession or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore City

PARENTS

10-NAME OF FATHER Charles A. Hobbs  
11-BIRTHPLACE OF FATHER (State or country) MD  
12-MAIDEN NAME OF MOTHER Mary Berdston  
13-BIRTHPLACE OF MOTHER (State or country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas A. Hobbs  
(Address) 2612 Riggs Ave

15 JAN 14 1915  
Filed 191

ROBERT L. ELLIOTT  
Bureau Permit Clerk  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan 14, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11, 1915, to, Jan 14, 1915, that I saw him alive on Jan 14, 1915, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:

Diphtheria

(Duration) yrs. mos. 3 ds.  
Contributory (SECONDARY) Cardiac Asthenia

(Signed), E. William Frey M.D.  
Jan 14, 1915 [Address] 1928 Penna Ave

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Jan 15, 1915  
John Cook 13076 N. Ave  
UNDERTAKER

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81902

## CERTIFICATE OF DEATH.

120 C81902

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; yrs.; mos.; ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED  
or DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

May 19, 1856  
(Month) (Day) (Year)

## 7-AGE,

58

7 yrs. 2 mos. 2 ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Conductor  
(b) General nature of industry, business, or establishment in which employed (or employer)... P. R. R.

## 9-BIRTHPLACE,

(State or Country),

Penn.

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

JAN 14 1915

ROBERT

KRAUTER,

Filed

M. L. L. Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 12, 1915.  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 6, 1915, to Jan 12, 1915,

that I saw him alive on Jan 12, 1915,

and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Jacob Fisher, M. D.

Jan 13, 1915. (Address) 1926 E. 6th St. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Marysville, Pa

Jan 15, 1915

UNDERTAKER

ADDRESS

Wm Cook

5076 North Ave

important. See instructions on back of certificate.





## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81904

## CERTIFICATE OF DEATH.

REGISTERED NO. C

64 C81904

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Byrd.

ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Brinnick.

Residence in Baltimore: No. 1704 Byrd.

St.: yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 6, 1861

7-AGE,

54 yrs. 7 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

House Wife.

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Samuel P. Brooks.

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Mary J. Tracey.

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E. Brinnick.

(Address) 1704 Byrd St.

15-

JAN 15 1915

HARRY O. ANDREWS,

Filed 1915 Mar 14 Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 13, 1915

I HEREBY CERTIFY, That I attended deceased from

Jan 12 1915, to Jan 13 1915,

that I saw her alive on Jan 13 1915,

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Jan 14, 1915 (Address) 1704 Byrd St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral.

DATE OF BURIAL,

Jan 16, 1915.

20-UNDERTAKER

Edw. J. Manning.

ADDRESS

1460 Battery Ave.

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81905

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81905

PLACE OF DEATH

CITY OF BALTIMORE: (No.

426 Harford Road

ST.:

WARD)

2. FULL NAME

Thomas C. Biddison

(Residence in Baltimore: No.

Gardenville Md.

St.: yrs., mos., ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

February

28

1886

(Month)

(Day)

(Year)

7-AGE,

28 yrs., 10 mos., 17 da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).

E. Scott Payne &amp; Co.

9-BIRTHPLACE, (State or Country),

Baltimore Co Md

10-NAME OF FATHER,

Thomas C Biddison

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Co Md

12-MAIDEN NAME OF MOTHER

Julia A. McCauley

13-BIRTHPLACE OF MOTHER (State or Country),

Anna Arundel Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John C. Biddison

(Address)

Raspburg Md

15-

Filed

JAN 15 1915

191

HARRY O. ANDREWS,

Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 14- 1915

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec-29

1914

to Jan 14-

1915

that I saw him alive on Jan 14-

1915

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH\* was as follows:

Rheumatic Endocarditis

Ill at times for past 14 yrs.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Last illness 17 days

(Duration) yrs. mos. da.

(Signed)

H. G. Andrews

M. D.

Jan 14, 1915. (Address) 624 E. Pratt St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Biddisons Family Cemetery

Jan 16, 1915

20-UNDERTAKER

ADDRESS

George Schilling &amp; Sons 1268 Monument

important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81906

## CERTIFICATE OF DEATH.

90

C81906

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

323 N. Carrollton ave. 18

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Garrett Altvater

(Residence in Baltimore: No.

323 N. Carrollton ave

St. yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH,

September 3<sup>rd</sup>, 1841

7-AGE,

78 yrs. 4 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer).

Beaver Dam Marble Co.

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

Garrett Altvater

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Louisa B. Williams

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mory G. Altvater

(Address)

323 N. Carrollton ave

15-

JAN 15 1915

HARRY O. ANDREWS

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan. 13, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 7, 1915, to Jan 13, 1915,

that I saw him alive on Jan 13, 1915,

and that death occurred, on the date stated above, at 11:15 P.m.

The CAUSE OF DEATH\* was as follows:

Chronic Bronchitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Septic Infection from absorption of Rubeola matter

(Duration) 3 yrs. mos. 3 ds.

(Signed) T. N. Tamm M. D.

Jan 14, 1915 (Address) 317 N. Carrollton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

DATE OF BURIAL,

Jan. 16<sup>th</sup>, 1915

20-UNDERTAKER

George Schilling &amp; Sons

ADDRESS

1126 E. Monument

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81907

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81907

CERTIFICATE OF DEATH.

PLACE OF DEATH  
CITY OF BALTIMORE (No. *University and Hop* ST. *5* WARD)  
FULL NAME *Mary Borodovsky*  
(Residence in Baltimore: No. *117 N Exeter* St.; yrs. *3* mos. *6* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)  
6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)  
7-AGE, *3* yrs. *6* mos. *6* ds. If LESS than 1 day, .... hrs. or .... min.  
8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *None*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Polto.*  
10-NAME OF FATHER, *Will Borodovsky*  
11-BIRTHPLACE OF FATHER (State or Country), *Russia*  
12-MAIDEN NAME OF MOTHER *Fannie Koschsky*  
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Will Borodovsky*  
(Address) *117 N Exeter St.*

15-  
Filed *JAN 15 1915* HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 15, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said *inquest*, and that said deceased came to *her* death *on the day stated above.*  
The CAUSE OF DEATH\* was as follows:

*Gun Shot wound of brain*  
*(accidental)*  
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....  
(Signed) *J. P. Jeffers* M. D.  
*Jan 15 1915* (Address) *113 N. E. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death..... yrs..... mos. *2* ds. *3* In the *3* yrs..... mos..... ds.  
Where was disease contracted, if not at place of death,.....  
*Glenburne A. Co. Md.*  
Former or usual residence *117 N. Exeter St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Jan 15, 1915*  
*Robert M. Carroll*  
20-UNDERTAKER, ADDRESS *107 E*  
*J. Linscott 134 Balto St*



C81908

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81908

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Harlem Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Mary E. Lindall

(Residence in Baltimore: No. 1516 Harlem Ave

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

widow

6-DATE OF BIRTH,

July 1, 1845

7-AGE,

69 yrs. 6 mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Edward Ferry

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Charity M. Tansand

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma T. Clark

(Address) 209 Goodwood Garden

15-

JAN 15 1915

HARRY O. ANIKES, Registrar.

1915 Burial Permit Clerk

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 14, 1915

I HEREBY CERTIFY, That I attended deceased from Feb 1st 1914, to Jan 14 1915, that I saw her alive on Jan 14 1915, and that death occurred, on the date stated above, at 7.30 p.m. The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver

(Cause of death)

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) 3 yrs. 1 mo. 14 ds.

(Signed) J. H. Stearns M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount

Jan 16 1915

20-UNDERTAKER

ADDRESS

E. M. Mitchell

1201 W. Fayette St.

important. See instructions on back of certificate.

C81909

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81909

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH UNION PROTESTANT INFIRMARY,  
CITY OF BALTIMORE (No. 1514 DIVISION STREET, St. 14 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME JOHN DONALDSON PARKER,

(Residence in Baltimore: No. NON-RESIDENT.

St.; yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, November 16th, 1873, (Month) (Day) (Year)

7-AGE, 41 yrs., 2 mos., 29 ds., If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Attorney at Law, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Foxall Alexander Parker,

11-BIRTHPLACE OF FATHER, (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Caroline Donaldson,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Pickering Parker,

(Address) 1728 Connecticut Ave.

15- JAN 15 1915 Washington St. 101. Serial Permit Clerk, Registrar.

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CEREBRAL HAEMORRHAGE DUE TO AN ACCIDENTAL FRACTURE OF THE SKULL.

(Duration) .... yrs. .... mos. 1 ds.

CONTRIBUTORY FALL FROM HORSE.

(Signed) J. Frederick Humpal, M. D. (Coroner)

Jan. 14, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 1 ds. In the State .... yrs. 2 mos. .... ds.

Where was disease contracted, if not at place of death?

Fall from horse on Joppa rd. Former or usual residence Towson Md.

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md. DATE OF BURIAL, 1-16-15

20-UNDERTAKER, H. W. Jenkins & Sons Cor. ADDRESS Orchard Me. Cullen

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81910

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81910

1 PLACE OF DEATH

2209

CITY OF BALTIMORE: (No.

2209 Brookfield Ave

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Henrich Becker

(Residence in Baltimore: No.

2209 Brookfield Ave

St.; yrs., mos., ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

April

2

1851

(Month)

(Day)

(Year)

7-AGE,

63

63

yrs.

9

mos.

12

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

Germany -

10-NAME OF FATHER,

Earl Becker

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany -

12-MAIDEN NAME OF MOTHER

Louise Hoen

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

H. Sonnenban -

(Address).

2209 Brookfield Ave

15-

JAN 15 1915

HARRY O. ALLENBROS,

Filed.

191

Burial Permit Clerk,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan.

14

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 25 1914, to Jan 14 1915,

that I saw him alive on Jan 13 1915,

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary edema, 2da

Chronic Dysentery, 3da

(Duration) 35 yrs. 1 mos. 1 ds.

CONTRIBUTORY  
(Secondary)

arterio Sclerosis

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed)

Geo. J. Hauss, Jr. M. D.

Jan 15, 1915 (Address) 1935 W. N. H. Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Jan 16, 1915

20-UNDERTAKER

H. J. Luckner &amp; Son

ADDRESS

Penna &amp; Smith

important. See instructions on back of certificate.

1935 W. N. H. Ave



81911

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1429 N. Patterson Park Ave.* ST.; *8* WARD)

### 2-FULL NAME

*Anna Elizabeth Schwindberg*

(Residence in Baltimore: No. *1429 N. Patterson Park Ave.* St.; — yrs. — mos. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*  
(Write the word.)

6-DATE OF BIRTH, *October 30, 1852*  
(Month) (Day) (Year)

7-AGE, *62* yrs. *2* mos. *14* ds. IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Conrad Dickel*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Simon Schwindberg husband*

(Address) *1429 N. Patterson Park Ave.*

15- JAN 15 1915

HARRY O. ANDREWS,

Filed..... 191. Mortal Permit Clerk Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 13, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 3, 1913*, to *Jan 13, 1915*, that I saw h. or alive on *Jan 12, 1915*, and that death occurred, on the date stated above, at *4:59* m.

The CAUSE OF DEATH\* was as follows:

*Parasitis*

(Duration) *2* yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) *Parasitis*

(Duration) .... yrs. .... mos. .... ds.

(Signed) *William E. Dingman, M. D.*

*1/13/15, 1915* (Address) *1507 E. North Ave.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Druid Hill Park Cemetery* DATE OF BURIAL, *Jan 15, 1915*

20-UNDERTAKER *Christian Miller* ADDRESS *3354 Jefferson St*

Important. See instructions on back of certificate.



C81912

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81912

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *822 N Wolfe* ST.; *7* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *ms Grace Henson Adams*(Residence in Baltimore: No. *822 N Wolfe* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED. (Write the word.)6-DATE OF BIRTH, *January 28, 1896*

(Month) (Day) (Year)

7-AGE, *18* yrs. *11* mos. *16* da.

If LESS than 1 day. .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House work*(b) General nature of industry, business, or establishment in which employed (or employer). *Domestic*9-BIRTHPLACE, (State or Country), *Beth. City.*10-NAME OF FATHER, *William Henson*11-BIRTHPLACE OF FATHER (State or Country), *MD*12-MAIDEN NAME OF MOTHER *Martha Harris*13-BIRTHPLACE OF MOTHER (State or Country), *MD*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Henson*(Address) *937 E. Union Place*

15 JAN 15 1915

HARRY O. ANDREWS,

Filed..... 1915 Burial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 14, 1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 22 1914*, to *Jan 14 1915*, that I saw him alive on *Jan 12 1915*, and that death occurred, on the date stated above, at *2, 30<sup>00</sup> m.*

The CAUSE OF DEATH\* was as follows:

*Pulmonary Phthisis**6 mo.* (Duration) .... yrs. .... mos. .... da.CONTRIBUTORY (Secondary) *Heart Failure & Exhaustion**6 mo.* (Duration) .... yrs. .... mos. .... da.(Signed) *Edward J. Jones* M. D.*Jan 14, 1915* (Address) *1612 E. Monument St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Not known*DATE OF BURIAL, *Jan 16, 1915*20-UNDERTAKER, *James H. Deane*ADDRESS, *1303 P. Street*

important. See instructions on back of certificate.

C81913

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

C81913

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Maryland General Hospital* ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1605 Presbury St.* St.: *1605* yrs. *1* mos. *19* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX.

*Female*

## 4-COLOR OR RACE,

*Black*5-SINGLE,  
MARRIED,  
WIDOWED,  
or *Married*  
(Write the word.)

## 6-DATE OF BIRTH.

*Unknown, 1876*  
(Month) (Day) (Year)

## 7-AGE,

*39*yrs. *1* mos. *19* ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laundress*9-BIRTHPLACE,  
(State or Country),*Baltimore*

## 10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER  
(State or Country),*Unknown*

## 12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country),*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry O. Andrews*(Address) *1605 Presbury St.*

## 15-

JAN 15 1915 HARRY O. ANDREWS,

Filed....., 191. *1605 Presbury St.* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 12, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Nov 25, 1914*, to *Jan 12, 1915*,that I saw her alive on *Jan 11, 1915*,and that death occurred, on the date stated above, at *4:30* m.

## The CAUSE OF DEATH\* was as follows:

*Chronic Bronchitis, dilatation of  
arteries, atherosclerosis, and  
hypertension*(Duration) *2* yrs. *1* mos. *19* ds.CONTRIBUTORY  
(Secondary)(Duration) *1* yrs. *1* mos. *19* ds.(Signed) *Chas. C. Ayres* M. D.*Jan. 15, 1915* (Address) *1605 Presbury St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *19* ds. In the State *1* yrs. *1* mos. *19* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1605 Presbury St.*

## 19-PLACE OF BURIAL OR REMOVAL.

*1605 Presbury St.*

## DATE OF BURIAL.

*Jan 15, 1915*

## 20-UNDERTAKER

*James H. Dumas, 303 Presbury St.*

## ADDRESS

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1527 N. MOUNT STREET, ST. 15 WARD)

2-FULL NAME WILLIAM G. BURR,

(Residence in Baltimore: No. 1527 N. MOUNT STREET.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, ~~White~~ Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widower, (Write the word.)

6-DATE OF BIRTH, April 14th, 1873. (Month) (Day) (Year)

7-AGE, 41 yrs., 8 mos., 29 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Porter, (b) General nature of industry, business, or establishment in which employed (or employer), in store.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, William G. Burr, sr.

11-BIRTHPLACE OF FATHER, (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Laura A. Gent,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Burr, brother,

(Address) 1527 N. Mount street.

15- JAN 15 1915 HARRY O. ANDREWS, Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 12th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

INTERNAL HAEMORRHAGE CAUSED BY A STAB-WOUND OF CHEST, (HOMICIDE)

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) Frederick Hempel, M. D. (Coroner)

Jan. 13, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

mt Auburn Cem Jan. 16, 1915

20-UNDERTAKER ADDRESS

Wm J Johnson 586 Baker st

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81915

C81915

## CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ....)

307 S. Mount

ST.: 19 WARD)

FULL NAME

William J. Bolden

(Residence in Baltimore: No. ....)

307 S. Mount

St.: 15 yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Nov

14

1857

(Month)

(Day)

(Year)

7-AGE,

57

yrs.

2

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Tool Dresser.

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF

FATHER,

Oder Bolden

11-BIRTHPLACE

OF FATHER

(State or Country),

Ireland.

12-MAIDEN NAME

OF MOTHER

Bridget Liberty.

13-BIRTHPLACE

OF MOTHER

(State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lennie B. Bolden

(Address)

307 S. Mount St.

15-

Filed

JAN 15 1915

HARRY O. ANDREAS,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January

14

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Nov 11 1914, to January 14 1915,

that I saw him alive on Jan 14 1915,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Coma

important. See instructions on back of certificate.

18-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cem

DATE OF BURIAL,

Jan. 15, 1915.

20-UNDERTAKER

Henry H. Jenkins, Sen. &amp; Son

Address

Orchard St.



## C81916 HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *102 N. Streper* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: *Barbara Dorn*(Residence in Baltimore: No. *102 N. Streper* St.; *50* yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, *Widow* OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Oct 4*, *1856*  
(Month) (Day) (Year)7-AGE, *58* yrs., *3* mos., *10* ds. If LESS than 1 day, ....hrs. or....min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work, *Retired*  
(b) General nature of industry, business, or establishment in which employed (or employer), *Barman*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Kennett*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nicholas Dorn*(Address) *159 W. Ebury St.*15-*JAN 15 1915* *HARRY O. ANDERSON*  
Filed..... 191. Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan. 12, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan. 4* 1915, to *Jan. 12* 1915, that I saw her alive on *Jan. 12* 1915, and that death occurred, on the date stated above, at *5.50* A. M. The CAUSE OF DEATH\* was as follows:*Lobar Pneumonia*(Duration)..... yrs. .... mos. *9* ds.CONTRIBUTORY *Pulmonary Edema*  
(Secondary)(Duration)..... yrs. .... mos. *2* ds.(Signed) *Geo. Heller* M. D.*Jan. 15*., 1915. (Address) *1937 Gough St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn Cemetery* DATE OF BURIAL, *Jan 16*., 1915.20-UNDERTAKER *Lilly & Zeller* ADDRESS *403 S. Wofford*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

## 5-SINGLE,

MARRIED,

WIDOWED,

(If more than one word)

## 6-DATE OF BIRTH,

## 7-AGE,

IF LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

## 15-

Filed.....

191.....

HARRY C. ANDREWS,  
Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

## 17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH\* was as follows:

## CONTRIBUTORY (Secondary)

Signed.....

Jan. 13 1915

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the State

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

## 20-UNDERTAKER

## ADDRESS

important. See instructions on back of certificate.

C81918

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81918

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1533 Fairmount ave* ST.; *19* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1533 Fairmount ave* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

## 4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day,

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,  
(State or Country),

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. M. Freeman*(Address) *University Hospital*

## 15-

Filed *JAN 15 1915* 191*5*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

## 17- I HEREBY CERTIFY, That I attended deceased from

*Dec 21 1914*, to *Jan 15 1915*,that I saw her alive on *Jan 14 1915*,and that death occurred, on the date stated above, at *2 a. m.*

The CAUSE OF DEATH\* was as follows:

*Fracture of skull*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Fracture of skull*

(Duration) yrs. mos. ds.

(Signed) *H. M. Freeman* M. D.191... (Address) *University Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*St. Auburn Cemetery* *Jan. 15, 1915*

## 20-UNDERTAKER

## ADDRESS

*Walter Owens* *318 North*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81919

## CERTIFICATE OF DEATH.

104

C81919

## 1-PLACE OF DEATH

CITY OF BALTIMORE (No.

602 S. Ellwood ave

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Dorothy Krauer

(Residence in Baltimore: No.

602 S. Ellwood ave

St.; yrs. / mos. / ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

November 25, 1913

(Month)

(Day)

(Year)

7-AGE,

yrs. 1 mos. 21 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Joseph M. Krauer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Theresa E. Seglinski

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jos M. Krauer

(Address)

602 S. Ellwood ave

15-

FILED

JAN 15 1915

HARRY O. ANDREWS,

Burial Permit Clerk

## CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 15, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Acute Gastritis

(Duration)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. A. Jones M. D.

(Coroner)

Jan 15, 1915 (Address) J. A. Jones

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Jan 16, 1915

20-UNDERTAKER

St. J. Sadowski

ADDRESS

705 S. Amity St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81920

C81920

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *229. N. Chester* ST.; *6* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *229. N. Chester* St.; *6* yrs. *—* mos. *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

*Married*

## 6-DATE OF BIRTH,

*April**22<sup>nd</sup>**1842*

(Month)

(Day)

(Year)

## 7-AGE,

*72**9**mos.**ds.*

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Bay Captain*9-BIRTHPLACE,  
(State or Country).*Wicomico Co. Md*

## 10-NAME OF FATHER,

*John Harrington*11-BIRTHPLACE OF FATHER  
(State or Country).*Wicomico Co. Md*

## 12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER  
(State or Country).*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Mrs. Etta Harrington*

(Address)

*229. N. Chester St.*

## 15-

JAN 15 1915

Filed

191

HARRY O. ANDREWS,

Bureau Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan.**13<sup>th</sup>**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 29* 1914, to *Jan 13* 1915, that I saw him alive on *Jan 13* 1915, and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH\* was as follows:

*Uremia*

(Duration)

*6**mos.**15*CONTRIBUTORY  
(Secondary)*Chronic Nephritis*

(Duration)

*4**mos.**15*

(Signed)

*John T. Speerwall M. D.*

(Address)

*2112 E. Baltimore St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Mt. Carmel Cn**Jan. 16., 1915*

## 20-UNDERTAKER

## ADDRESS

*Geo M. Finner**811 N. W. 7<sup>th</sup>*

important. See instructions on back of certificate.

C81921

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81921

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *810 Ridgely* ST.; *21* WARD)

REGISTERED No. C

2-FULL NAME *Wm Reuter*(Residence in Baltimore: No. *810 Ridgely* St.; *56* yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, *Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)6-DATE OF BIRTH, *June* *11*, *1844*

(Month)

(Day)

(Year)

7-AGE, *70* yrs. *7* mos. *2* ds.

If LESS than 1 day,

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Shoe maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Reuter*(Address) *810 Ridgely*

## 15-

JAN 16 1915

HARRY O. ANDERSON

Filed

191

Burial Permit Glan

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan* *13*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 7* 1915, to *Jan 13* 1915,that I saw him alive on *Jan 13* 1915,and that death occurred, on the date stated above, at *6:40* m.

The CAUSE OF DEATH\* was as follows:

*Cardiac Syncope*(Duration) *few minutes*

yrs.

mos.

ds.

CONTRIBUTORY *Senile Debility*

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) *G. Reuter Ewell*

M. D.

11/15/15, 191... (Address) *905 N. Glen St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *Jan 16, 1915*20-UNDERTAKER, *Mr. W. W. Brown*ADDRESS *2503 Edmondson Ave*

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81922

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Luke's Hosp.* ST. *23* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1022 Sharp*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *49* yrs., — mos. *15* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*white*

## 5-SINGLE,

*Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Dec 29*, *1865*  
(Month) (Day) (Year)

## 7-AGE,

*49* yrs. *0* mos. *15* ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*B. & O. R. R.*  
*Fireman*9-BIRTHPLACE,  
(State or Country),*City*

## 10-NAME OF FATHER,

*Louis Cornell*11-BIRTHPLACE OF FATHER  
(State or Country)*Don't know*

## 12-MAIDEN NAME OF MOTHER

*Emily M.*13-BIRTHPLACE OF MOTHER  
(State or Country)*Don't know*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Delimp*(Address) *1022 Sharp St.*

## 15-

Filed *JAN 16 1915* HARRY O. ANDREWS,  
101... *Burial Permit* 015...  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan.* *13*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*Dec. 7* 191*4*, to *Jan 13* 191*5*,  
that I saw him alive on *Jan 17* 191*5*,  
and that death occurred, on the date stated above, at *2a* m.  
The CAUSE OF DEATH\* was as follows:*Cardiac Scurvy*

(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)*Typhoid Fever*  
*Since Dec 7-14*

(Duration) yrs. mos. ds.

## (Signed)

*G. Patrick Cowell* M. D.  
*1/13*, 191*5* (Address) *905 N. Ketchum St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *20* ds. In the *City* State *MD.* yrs. mos. ds.Where was disease contracted, if not at place of death? *In my judgement at his work*Former or usual residence *1022 Sharp St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*London Park*

## DATE OF BURIAL,

*Jan 17, 1915*

## 20-UNDERTAKER

*Gen. Weber & Son 2823 E. Snowden Ave.*

important. See instructions on back of certificate.



state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81923

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

28 C81923  
REGISTERED No. C.

### 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 553 St Marys Ct ST. 17 WARD)

### 2-FULL NAME

Geneva Holmes

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

### (Residence in Baltimore: No.

553 St Marys Ct

St.; yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

#### 3-SEX

Female

#### 4-COLOR OR RACE

col

#### 5-SINGLE

Single  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word)

#### 6-DATE OF BIRTH

Sept 14 1893  
(Month) (Day) (Year)

#### 7-AGE

22 yrs. 4 mos. 4 ds. or min.?

#### 8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

#### 9-BIRTHPLACE (State or country)

Washington D.C.

#### 10-NAME OF FATHER

William Holmes

#### 11-BIRTHPLACE OF FATHER (State or country)

St Marys County Md

#### 12-MAIDEN NAME OF MOTHER

Mary Wood

#### 13-BIRTHPLACE OF MOTHER (State or country)

St Marys Co Md

#### 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Miles Mother

(Address) 553 St Marys Ct

### MEDICAL CERTIFICATE OF DEATH

#### 16-DATE OF DEATH

Jan 14 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 11 1915, to Jan 14 1915, that I saw her alive on Jan 11 1915, and that death occurred, on the date stated above, at 9:30 p.m.  
The CAUSE OF DEATH\* was as follows:

Consumption Pulmonary  
39 St Marys

(Duration) yrs. mos. ds.

#### Contributory (SECONDARY)

Exhaustion  
(Duration) yrs. mos. ds.

(Signed) Samuel R. Bain M.D.  
Jan 15 1915 [Address] 937 Madison St

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

#### 18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

#### 19-PLACE OF BURIAL OR REMOVAL

#### DATE OF BURIAL

St Peter's Church

Jan 16 1915

#### 20-UNDERTAKER

#### ADDRESS

Samuel Easton

916 Penna Ave

#### 15-

#### FILE

JAN 16 1915

101

ROBERT J. HANLEY  
Bureau of Health  
REGISTRAR



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# C81924 HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

64 C81924  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *212 1/2 N Greene St.*)

ST. *4* WARD)

2-FULL NAME

*Frederick William Krausch*

(Residence in Baltimore: No. *212 1/2 N Greene*)

St. *2* yrs. *1* mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

*Married*

6-DATE OF BIRTH

*Dec.*

*8*, 18*51*

(Month)

(Day)

(Year)

7-AGE

*63*

yrs.

*1*

mos.

*6*

ds.

If LESS than

1 day, ---hrs.

or ---min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Cigar Maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Tobacco*

9 BIRTHPLACE

(State or country)

*Lehitzsch Germany*

10 NAME OF FATHER

*August Krausch*

11 BIRTHPLACE OF FATHER

(State or country)

*Germany*

12 MAIDEN NAME OF MOTHER

*Johanna R. Kunert*

13 BIRTHPLACE OF MOTHER

(State or country)

*Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mr. F. Krausch*

(Address)

*822 Hanover*

15.

ROBERT

CRAUTER

Filed JAN 16 1915

Burial Permit Clerk

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Jan*

*14*

, 19*15*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 13*

, 19*15*

to *Jan 14*

, 19*15*

that I saw him alive on

*Jan. 14*

, 19*15*

and that death occurred, on the date stated above, at *6:09 P. m.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*

(Duration) *0* yrs. *0* mos. *1* ds

Contributory

(SECONDARY)

*none*

(Duration) yrs. mos. ds.

(Signed), *R. B. Thompson*

M. D.

*Jan 14*

, 19*15*

(Address) *422 N Greene*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park*

*Jan 15*, 19*15*

20-UNDERTAKER

ADDRESS

*J. A. Krausch 703 Hanover*

C81925

## HEALTH DEPARTMENT-CITY OF BALTIMORE

C81925

## CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1118 Warner*)

ST

WARD)

FULL NAME *Geo. W. Smith*(Residence in Baltimore: No. *1118 Warner*)St.: *76* yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE, MARRIED, WIDOWED, OR DIVORCED

(Write the word)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

If LESS than

1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Dec 10, 1915, to Jan 14, 1916.

that I saw him alive on " " 1915.

and that death occurred, on the date stated above, at 7:42 a.m.

The CAUSE OF DEATH\* was as follows:

*Pneumonia with heart**about*

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Jan 15, 1916

(Address)

*717 Carrollton*

M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*National Ct**Jan 18, 1916*

UNDERTAKER

ADDRESS

*L. H. Brown & Son**108 W. Montgo*

15

ROBERT J. KRAUTER,

JAN 18, 1916

Burial in Senate Clerk.

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N. Arlington ST. WARD) 16

2-FULL NAME Thomas Quillian

(Residence in Baltimore: No. 1015 N. Arlington St.; yrs. mos. ds.)

REGISTERED NO. C. 28 C81926

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE

MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

single

6-DATE OF BIRTH

unknown 7 8 4  
(Month) (Day) (Year)

7-AGE

51

yrs. mos. ds. or min.?

11 LESS than  
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Driver

9-BIRTHPLACE  
(State or country)

MD

10-NAME OF FATHER

James Quillian

11-BIRTHPLACE OF FATHER  
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Bridget B. Ryan

13-BIRTHPLACE OF MOTHER  
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. T. Quillian  
(Address) 1015 N. Arlington St.

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 15, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 15, 1914, to January 15, 1915,

that I saw him alive on January 15, 1915,

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis  
Pulmonalis

(Duration) yrs. mos. ds.

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Chas. T. Chamberlain M.D.

January 15, 1915 [Address] 1015 N. Arlington St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death at home mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

Jan 18, 1915

20-UNDERTAKER

Martin Fahy & Sons

ADDRESS

106 Lafayette St.

15- JAN 16 1915

Filed 191

ROBERT . KRAUTER,

Sanitary Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C81927

PLACE OF DEATH

CITY OF BALTIMORE (No. 5 & High

ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Gordon

(Residence in Baltimore: No. 5 & High

Sr. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married

(Write the word)

6-DATE OF BIRTH

Unknown, 1

(Month)

(Day)

(Year)

7-AGE

57 yrs. 5 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Russia

PARENTS

10-NAME OF FATHER

David Gordon

11-BIRTHPLACE OF FATHER

(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam Gordon

(Address)

5 & High st

JAN 16 1915

ROBERT KRAUTH

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan

15, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 3, 1915, to Jan 15, 1915,

that I saw him alive on Jan 14, 1915,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Ovary

(Duration) One yr. mos. ds.

Contributory (SECONDARY)

uraemia

(Duration) yrs. mos. 3 ds.

(Signed)

C. F. Blake

M. D.

Jan 15, 1915 (Address) 70 E. Preston

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

5 & High st

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Maple Rosedale

Jan 17, 1915

UNDERTAKER

ADDRESS

1107 E. Baltimore Ave Balto Md



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81928

C81928

## CERTIFICATE OF DEATH.

91  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Children Hospital* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *Abner Hospital* St.; yrs. *4* mos. *14* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, <input checked="" type="checkbox"/> MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> OR DIVORCED, <input type="checkbox"/> (Write the word.)
--------------------	-------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## 6-DATE OF BIRTH,

*July 20, 1914*  
(Month) (Day) (Year)

## 7-AGE,

*5 yrs. 2 mos. 29 ds.* If LESS than 1 day, ....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank M. Mott*(Address) *419 S. Paul St.*

15- JAN 16 1915 ROBERT JOHNS HOPKINS HOSPITAL

Filed..... 191..Burial Permit Clerk. Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*January 12, 1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 7 1915*, to *Jan 12 1915*,

that I saw him alive on *Jan 11 1915*,

and that death occurred, on the date stated above, at *6 A m.*

## The CAUSE OF DEATH\* was as follows:

*Broncho Pneumonia*

(Duration).....yrs.....mos.....ds.

## CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Harry E. Eber* M. D.

*Jan. 13, 1915* (Address) *Abner Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death yrs. *4* mos. *14* ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? *Abner Hospital*

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

....., 191...

## 20-UNDERTAKER

## ADDRESS

FOR ANATOMICAL PURPOSES.

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81929

CERTIFICATE OF DEATH.

91/16  
C81929

PLACE OF DEATH

CITY OF BALTIMORE (No. 1624 CHALK ALLEY,

ST.

WARD)

FULL NAME: GLADYS FREEMAN,

(Residence in Baltimore: No. 1624 CHALK ALLEY.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, Female, 4-COLOR OR RACE, Colored, 5-SINGLE, Married, Widowed, or Divorced, Single, (Write the word.)

6-DATE OF BIRTH, December 14th, 1914. (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Oliver Freeman,

11-BIRTHPLACE OF FATHER, Unknown, (State or Country).

12-MAIDEN NAME OF MOTHER, Viola Jackson,

13-BIRTHPLACE OF MOTHER, Baltimore, Md. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Freeman, mother,

(Address)

15 JAN 16 1915 ROBERT E. KRAUSE, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 12th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

BRONCHO-PNEUMONIA,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Frederick H. Humpel, M. D. (Coroner)

Jan. 12, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL, DATE OF BURIAL, JAN 15 1915

20-UNDERTAKER, ADDRESS

FOR ANATOMICAL PURPOSES

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81930

## CERTIFICATE OF DEATH.

64 C81930  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital 19*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Robert S. Bowley*(Residence in Baltimore: No. *225 N. Carroll St.*)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*Black*

## 5-SINGLE, MARRIED, or SEPARATED

*Married*

## 6-DATE OF BIRTH,

....., 1.....  
(Month) (Day) (Year)

## 7-AGE,

*52*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9-BIRTHPLACE, (State or Country),

*Md.*

## PARENTS.

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER (State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JAN 16 1915

ROBERT S. KRAUTER,

Filed.....

191.....

Burial Permitt. Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Dec. 31, 1914*  
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Dec. 25, 1914*, to *Dec. 31, 1914*,that I saw him alive on *Dec. 31, 1914*and that death occurred, on the date stated above, at *5:15 a.m.*

The CAUSE OF DEATH\* was as follows:

*General Arterio Sclerosis**Coronary Artery Disease*CONTRIBUTORY (Secondary) *Cerebral Hemorrhage*

(Duration) yrs. mos. ds.

(Signed) *Edward J. Smith* M. D.*Dec. 31, 1914* (Address) *Mercy Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *225 N. Carroll St.*Former or usual residence *225 N. Carroll St.*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*HOPKINS HOSPITAL*

....., 191.....

## 20-UNDERTAKER

## ADDRESS

FOR ANATOMICAL PURPOSES

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81931

## CERTIFICATE OF DEATH.

C81931

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 8

WARD)

## 2-FULL NAME

Mary Hopkins No. 8  
Mildred Holmes

(Residence in Baltimore: No.

1634 St. Joseph St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. da)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

Black

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Single

## 6-DATE OF BIRTH

Unknown

(Month) (Day) (Year)

## 7-AGE,

7 yrs. 7 mos. da.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country),

md.

## 10-NAME OF FATHER,

Elizabeth Holmes

11-BIRTHPLACE OF FATHER  
(State or Country),

Unknown

## 12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country),

Unknown

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P. Phelps

(Address)

John Hopkins Hosp.

## 15-

Filed JAN 16 1915

ROBERT . KRAUTSE

Burial Permit Officer

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January

2, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 12 1915, to Jan 12 1915,

that I saw him alive on

Jan 12 1915,

and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 2 da.

CONTRIBUTORY  
(Secondary)

Tuberculosis

(Duration) yrs. mos. 7 da.

(Signed)

Alvin S. Rothholz

M. D.

Jan. 12, 1915. (Address) John Hopkins Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 da. State yrs. 7 mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

1634 St. Joseph St.

## 19-PLACE OF BURIAL OR REMOVAL,

JOHNS HOPKINS HOSPITAL

## DATE OF BURIAL,

JAN. 15 1915

## 20-UNDERTAKER

Commissioner Health.

## ADDRESS

important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

## CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than  
1 day, hrs.,  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15-JAN 16 1915

ROBERT KRAUTER,

Filed

191

BURIAL PERMIT CLERK  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed) William H. Schwarz, M. D.  
January 8, 1915 [Address] Md. Penitentiary.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

JAN 15 1915

20-UNDERTAKER

Comptroller Health.

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81933

## CERTIFICATE OF DEATH.

156 C81933

PLACE OF DEATH

CITY OF BALTIMORE (No. 640 W Fayette St., 4 WARD)

FULL NAME

Residence in Baltimore: No. 640 W Fayette

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

Unknown

7-AGE.

55 about

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Prano-Lines

9-BIRTHPLACE.  
(State or Country).

Unknown

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER  
(State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JAN 16 1915

ROBERT

Bar. L. Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Jan 3, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Asphyxiation  
Illuminated gas - Suicide  
(Duration) yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Signed) J. B. Dwyer M. D.  
(Coroner)  
Jan 17 1915 (Address) 413 N. Carrollton Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

JAN 13 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1934 HEALTH DEPARTMENT—CITY OF BALTIMORE 175081934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. 116 N. Payson St.)  
2-FULL NAME Samuel S. Albrecht  
(Residence in Baltimore: No. 116 N. Payson St.)  
REGISTERED No. C  
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
St. 20 WARD  
St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male  
4-COLOR OR RACE, White  
5-SINGLE, MARRIED, married  
6-DATE OF BIRTH, Nov. 20<sup>th</sup>, 1869  
7-AGE, 45 yrs., 1 mos., 24 ds.  
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer), Candy  
9-BIRTHPLACE, (State or Country), Balt. Md.  
10-NAME OF FATHER, Chas. Albrecht  
11-BIRTHPLACE OF FATHER (State or Country), Germany  
12-MAIDEN NAME OF MOTHER, Margaret Blankner  
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Harry Albrecht  
(Address) 116 N. Payson St.

15-JAN 16 1915  
Filed 1915  
ROBERT E. RAUTER, Registrar  
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14<sup>th</sup>, 1915  
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, thereon and from the evidence obtained by said Inquest, and that said deceased came to death on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
Ruptured Spleen  
(Ran over by wagon) accident  
CONTRIBUTORY Internal Hemorrhage  
(Signed) Samuel Winberg, M. D.  
Jan. 14<sup>th</sup>, 1915 (Address) 302 Madison Ave.  
\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place of death, In the State, Where was disease contracted, if not at place of death.  
Former or usual residence.  
19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery  
20-UNDERTAKER, Geo. A. Gerber  
DATE OF BURIAL, Jan. 16 1915  
ADDRESS, 116 N. Payson St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81935

## CERTIFICATE OF DEATH.

120  
REGISTERED NO. C

C81935

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 Hickory Ave. ST.; 13 WARD)

## 2-FULL NAME

Eliza J. Hanes

Residence in Baltimore: No.

315 Hickory Ave.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

## 6-DATE OF BIRTH

June 24, 1856  
(Month) (Day) (Year)

## 7-AGE

58 yrs. 6 mos. 21 ds.

If LESS than 1 day.  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housekeeper

9-BIRTHPLACE,  
(State or Country).

Maryland

## 10-NAME OF FATHER

Samuel J. Young

11-BIRTHPLACE OF FATHER  
(State or Country).

Maryland

## 12-MAIDEN NAME OF MOTHER

Jemima Stanford

13-BIRTHPLACE OF MOTHER  
(State or Country).

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hanes

(Address) 315 Hickory Ave.

## 15-

JAN 16 1915

ROBERT E. RAUTER

MORTAL PERMIT CLERK

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

January 15, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 14, 1915, to January 14, 1915, that I saw her alive on Jan 14, 1915, and that death occurred, on the date stated above, at 2:00 PM.

The CAUSE OF DEATH\* was as follows:

Edema of lungs.  
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY  
(Secondary)Intermittent cheilitis.  
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Kelley M. D.

January 15 1915. (Address) 2849 Roland Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Mary's (Hamden) Jan. 16, 1915

UNDERTAKER

Horace Bungee &amp; Son 3631 Falls Road

important. See instructions on back of certificate.



state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

081936

# HEALTH DEPARTMENT--CITY OF BALTIMORE

## CERTIFICATE OF DEATH

54

C81936

1-PLACE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No. 1013 W Foyette ST. 18 WARD)

2-FULL NAME Frank J. Lubbehusen

(Residence in Baltimore: No. 1013 W Foyette St St. 22 yrs. 7 mos. 8 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE W 5-SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH APR 7 1892  
(Month) (Day) (Year)

7-AGE 22 yrs. 9 mos. 8 ds. or If LESS than 1 day, hrs., min.?

8-OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
Plumber

9-BIRTHPLACE (State or country) Balt.

PARENTS  
10-NAME OF FATHER Frank J. Lubbehusen  
11-BIRTHPLACE OF FATHER (State or country) Balt.  
12-MAIDEN NAME OF MOTHER Jean C. Cooper  
13-BIRTHPLACE OF MOTHER (State or country) Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Frank J. Lubbehusen Sr.  
(Address) 1013 W Foyette St

JAN 16 1915  
Filed

ROBERT F. FRAUTER,  
Burial Permit Clerk,  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 15, 1915  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 27, 1914, to Jan 15, 1915, that I saw him alive on Jan 14, 1915, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows:

Permeious Anaemia

(Duration) yrs. 2 mos. ds.  
Contributory (SECONDARY) Unknown  
(Duration) yrs. mos. ds.  
(Signed) J. J. Morrison M. D.  
Jan 15, 1915 [Address] 939 W Foyette

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Redeemer DATE OF BURIAL Jan 15, 1915  
ADDRESS 939 W Foyette

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81937

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81937

CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
CITY OF BALTIMORE (No. *208 W Mulberry* ST.: *4170* WARD)  
2-FULL NAME *James F Miller*  
(Residence in Baltimore: No. *208 W Mulberry* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*  
(Write the word.)  
6-DATE OF BIRTH, *Unknown*, 1  
(Month) (Day) (Year)  
7-AGE, *55* yrs. mos. ds. IF LESS than 1 day, ... hrs. or ... min.?  
8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Wall Paperer*  
(b) General nature of industry, business, or establishment in which employed (or employer).  
9-BIRTHPLACE, (State or Country), *Balto*  
10-NAME OF FATHER, *Unknown*  
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*  
12-MAIDEN NAME OF MOTHER, *Unknown*  
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Glantz*  
(Address) *208 W Mulberry St*

15- *JAN 16 1915* *ROBERT KRAUTER*  
Filed. 191. *Burial Permit Clerk* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 13, 1915*  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*  
(Inquest, autopsy or inquiry.)  
thereon and from the evidence obtained by said *inquiry*  
(Inquest, au-  
topsy or inquiry.) find that said deceased came to *his* death  
on the day stated above.  
The CAUSE OF DEATH\* was as follows:  
*uremia*  
*Interlobular nephritis*  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) *J. H. Jeffers* M. D.  
(Coroner) *James H. Carrollton*  
1915 (Address) *434 Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Baltimore County* *Jan 16, 1915*  
20-UNDERTAKER *Wm Roukous* ADDRESS *230 N Green*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81938

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *301 N. Fremont* ST. *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *301 N. Fremont* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Female*

4-COLOR OR RACE

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Single*

6-DATE OF BIRTH,

*Aug 15, 1892*

(Month) (Day) (Year)

7-AGE,

*47*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

*Dress maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

*Puerto Rico*

10-NAME OF FATHER,

*John Spangler*

11-BIRTHPLACE OF FATHER,

(State or Country),

*Puerto Rico*

12-MAIDEN NAME OF MOTHER

*Unknown*

13-BIRTHPLACE OF MOTHER,

(State or Country),

*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Miss Belle Collins*

(Address)

*301 N. Fremont*

15-

Filed

*JAN 16 1915*

ROBERT A. KRAUTER,

MARITAL Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Jan 14, 1915*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

*inquest* and that said deceased came to *his* death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Acute Cardiac Dilatation*

*Edema of Lung*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Carroll* M. D.

(Coroner) *J. H. Carroll*

(Address) *230 N. Greene*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Baltimore Cemetery*

*Jan 16, 1915*

20-UNDERTAKER

ADDRESS

*Wm. Morrison*

*230 N. Greene*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq Hosp* ST.; *18* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *115 Carey* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Female*

## 4-COLOR OR RACE.

*White*5-SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED,  
(Write the word.) *Married*

## 6-DATE OF BIRTH.

*Jan* (Month) *1* (Day) *1873* (Year)

## 7-AGE,

*42* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*

## 9-BIRTHPLACE,

(State or Country), *Va*

## 10-NAME OF FATHER,

*Davis Bray*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Va*

## 12-MAIDEN NAME OF MOTHER

*Joseph Marsh*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Va*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Oscar Hamilton*(Address) *115 Carey St*

## 15-

JAN 16 1915

ROBERT J. TRAUTER,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* (Month) *13* (Day) *1915* (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 8* 191*4*, to *Jan 13* 191*5*, that I saw her alive on *Jan 13* 191*5*, and that death occurred, on the date stated above, at *4 p. m.*

The CAUSE OF DEATH\* was as follows:

*Lobar pneumonia*(Duration) yrs. mos. ds. *12 ds.*

## CONTRIBUTORY (Secondary)

*Dilatation of right heart*(Duration) yrs. mos. ds. *1/2 ds.*(Signed) *A. Lee Hickey* M. D.*1/13/15* 191*5* (Address) *Franklin Sq. Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *3* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *115 Carey St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Green Park*

## DATE OF BURIAL,

*Jan 16*, 191*5*

## 20-UNDERTAKER

*John J. Fields 1200 W. Lombard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ✓)

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *Heneka Solovoski*(Residence in Baltimore: No. *612 S. Bethel St.*St.; *15* yrs., *—* mos., *—* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word.) *Single*6. DATE OF BIRTH *Jan. 18, 1899*

(Month)

(Day)

(Year)

7. AGE *15-6*yrs. *6* mos. *27* ds.

If LESS than 1 day.

...hrs. or ...min.?

## 8. OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- 
- (b) General nature of industry, business, or establishment in which employed (or employer).

*child*9. BIRTHPLACE, (State or Country), *Md.*10. NAME OF FATHER *William*11. BIRTHPLACE OF FATHER (State or Country), *Germany*12. MAIDEN NAME OF MOTHER *Elizabeth Kempf*13. BIRTHPLACE OF MOTHER (State or Country), *Germany*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Solovoski*(Address) *612 S. Bethel St.*15. *AN 16 1915*

Filed....., 191.....

HARRY O. ANDREWS

Burial Permit Officer

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH, *Jan. 14, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 31, 1914*, to *Jan. 14, 1915*, that I saw him alive on *Jan. 14, 1915* and that death occurred, on the date stated above, at *10.00* m.

The CAUSE OF DEATH\* was as follows:

*Pericarditis & Endocarditis*CONTRIBUTORY (Secondary) *about*

(Duration)

yrs.

mos.

ds.

(Signed) *Edward P. Smith*

M. D.

*Jan. 14, 1915* (Address) *Mercy Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death? *612 S. Bethel St.*Former or usual residence *612 S. Bethel St.*19. PLACE OF BURIAL OR REMOVAL, *Schmartz Cam*DATE OF BURIAL, *Jan. 16, 1915*20. UNDERTAKER *Wm Cook*ADDRESS *North & Lehigh Sts.*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81941

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

64

81941

### 1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1305* *Narford Ave* ST. *9* WARD)

2-FULL NAME *Charles F. Platen*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1305* *Narford Ave*)

St. *4* yrs., *—* mos., *—* ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, *Married*  
(Write the word.)

6-DATE OF BIRTH, *Nov 12*, *1842*  
(Month) (Day) (Year)

7-AGE, *72* yrs., *2* mos., *3* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *Sexton*  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), *Germany*

10-NAME OF FATHER, *Ernest Platen*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Josephine Platen*  
(Address) *1305 Narford Ave*

15- *JAN 16 1915* HARRY O. ANDREWS, Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 15*, *1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*  
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Signed) *Oliver Russell* M. D. (Coroner.)  
*Jan 15, 1915* (Address) *423 N. Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *Baltimore City* DATE OF BURIAL, *Jan 15, 1915*

20-UNDERTAKER *William Cook* ADDRESS *507 E. North*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81942

## CERTIFICATE OF DEATH.

79 REGISTERED NO. C

C81942

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Poplar Grove St.; 15 WARD)

2-FULL NAME *Wilhelmina J. Weiler*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1815 Poplar Grove St.; 60 yrs., - mos. - ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *about*6-DATE OF BIRTH, *Oct 21, 1844* (Month) (Day) (Year)7-AGE *70* yrs. *2* mos. *23* ds. If LESS than 1 day, .... hrs. or .... min.?8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *wine*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Schwartz*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Augusta Peters*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Philip Weiler*(Address) *1815 Poplar Grove St.*15- *JAN 16 1915* HARRY O. ANDREWS,

Filed..... 191... Serial Permit Clerk Registrar.

## MEDICAL CERTIFICATE OF DEATH.

8-DATE OF DEATH, *Jan 15, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 9* 1914, to *Jan 15* 1915, that I saw her alive on *Jan 15* 1915, and that death occurred, on the date stated above, at *12* o'clock.

The CAUSE OF DEATH\* was as follows:

*Chronic Valvular Heart Disease*(Duration) *Over 3* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *None* mos. .... ds.(Signed) *Henry C. White* M. D.*Jan. 16, 1915* (Address) *1203 W. Fayette St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Green Ridge Cemetery Jan 18 1915*

20-UNDERTAKER ADDRESS

*Jos. Friedens, San 217 S. Penn*

important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81943

C81943

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1643* *Oleans* St.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *1643* *Oleans* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*female*

## 4-COLOR OR RACE.

*Negro*5-SINGLE, *Single*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH.

*November, 1*  
(Month) (Day) (Year)

## 7-AGE.

*14* yrs. mos. ds.If LESS than 1 day.  
...hrs. or ...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.  
(State or Country).*MD*

## 10-NAME OF FATHER.

*Wileman*11-BIRTHPLACE OF FATHER  
(State or Country).*Wileman*

## 12-MAIDEN NAME OF MOTHER

*Wileman*13-BIRTHPLACE OF MOTHER  
(State or Country).*Wileman*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Stedger*(Address) *1506 Jefferson St.*

15- JAN 16 1915

Filed. 191

HARRY O. ANDREWS,

Burial Point, City.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 15, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 13* 1915, to *Jan 15* 1915, that I saw him alive on *Jan 15* 1915, and that death occurred, on the date stated above, at *2:00* p.m.

The CAUSE OF DEATH\* was as follows:

*Asthma, long standing*  
*Heart*  
(Duration) yrs. *1* mos. *14* ds.CONTRIBUTORY  
(Secondary)*Heart*  
(Duration) yrs. *1* mos. *14* ds.(Signed) *D. W. Hemmard* M. D.  
*Jan 15, 1915* (Address) *708 Emerson St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

*Polse Moke City, Md.*

## DATE OF BURIAL.

*Jan 17, 1915*

## 20-UNDERTAKER

*Charles B Jones*

## ADDRESS

*504 Rogers St.*

Important. See instructions on back of certificate.



C81944

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *613 Collett*ST. *15* WARD)

REGISTERED NO. C

## 2-FULL NAME

(Residence in Baltimore: No. *613 Collett St*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

## 6-DATE OF BIRTH

*Jan 10, 1850*  
(Month) (Day) (Year)

## 7-AGE

*65 - 4*  
yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Boiler*

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9-BIRTHPLACE, (State or Country)

*Ind*

## 10-NAME OF FATHER

*John Dorsey*

## 11-BIRTHPLACE OF FATHER

(State or Country), *Ind*

## 12-MAIDEN NAME OF MOTHER

*Susan Cook*

## 13-BIRTHPLACE OF MOTHER

(State or Country), *Ind*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mary Dorsey*(Address) *613 Collett St*

15 JAN 16 1915

HARRY O. ANDREWS,

Filed

1915

Serial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 14, 1915*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Dec 10* 191*5*, to *Jan 12* 191*5*,that I saw him alive on *Jan 12* 191*5*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*  
(Duration) yrs. 2 mos. ds.

## CONTRIBUTORY (Secondary)

*arterio-sclerosis*  
(Duration) yrs. 3 mos. ds.

## (Signed)

*Chas. H. Clautier, M. D.**Jan 15* 191*5* (Address) *548 N. Market St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*St. Dunstan**Jan 17, 1915*

## 20-UNDERTAKER

## ADDRESS

*Harriet C. Smith**1364 N. E. St*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81945

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

C81945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19)

2-FULL NAME

(Residence in Baltimore: No. 12)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 6 yrs 8 mos. In the 12 yrs. State 12 yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JAN 16 1915

HARRY O. ANDREWS,

Burial Permit Clerk REGISTRAR

George J. Smith.

Jan 21, 1915

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81946

## CERTIFICATE OF DEATH.

37

C81946

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Mathew Wilson*(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *9* mos. *23* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED, *single*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*August 18th, 1914.*  
(Month) (Day) (Year)

## 7-AGE,

*4 mos. 26 ds.*

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, business, or establishment in which  
employed (or employer).*None*9-BIRTHPLACE,  
(State or Country),*Maryland*10-NAME OF  
FATHER,*Unknown*11-BIRTHPLACE  
OF FATHER  
(State or Country),*Unknown*12-MAIDEN NAME  
OF MOTHER*Unknown*13-BIRTHPLACE  
OF MOTHER  
(State or Country),*Unknown*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1721 Division St.*

## 15-

JAN 16 1915 HARRY Q. ANDREWS,  
Registrar, Baltimore

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan. 14th, 1915.*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
*January 1st 1915*, to *January 17 1915*,  
that I saw him alive on *January 14th 1915*,  
and that death occurred, on the date stated above, at *8:30 P. m.*

The CAUSE OF DEATH\* was as follows:

*Congenital Syphilis*  
(Duration) *4 mos. 26 ds.*CONTRIBUTORY  
(Secondary)(Signed) *Leonard M. C. Parker* M. D.  
*Jan 15, 1915* (Address) *835 N. Fulton*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *23* ds. In the State yrs. *4* mos. *26* ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence*St. Vincent's Infirmary*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Cathedral Jan. 14, 1915*

## 20-UNDERTAKER

## ADDRESS

*Martha Fahney, 606 Lafayette*

important. See instructions on back of certificate.

C81947

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81947

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3404 Stafford

ST.: 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Walter B. Peregoy

(Residence in Baltimore: No. 3404 Stafford

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Male

## 4-COLOR OR RACE

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

married

## 6-DATE OF BIRTH,

Unknown, 1

(Month) (Day) (Year)

## 7-AGE,

35

yrs. mos. ds.

## 11-LESS than 1 day.

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Bar tender

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,  
(State or Country),

Baet

## PARENTS.

## 10-NAME OF FATHER,

David Peregoy

11-BIRTHPLACE OF FATHER  
(State or Country),

Baet

## 12-MAIDEN NAME OF MOTHER

Mary Francis

13-BIRTHPLACE OF MOTHER  
(State or Country),

Baet

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. G. Peregoy

(Address) 3511 Old Fred. Rd.

JAN 16 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk, Registrar.

## 16-DATE OF DEATH,

Jan 15, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1915, to Jan 15 1915, that I saw him alive on Jan 15 1915, and that death occurred, on the date stated above, at 9:14 m.

The CAUSE OF DEATH\* was as follows:

Laryngeal &amp; Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W. Jones M. D.

Jan 12, 1915. (Address) 3511 Old Fred. Rd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Linden Park

## DATE OF BURIAL,

Jan 17, 1915

## ADDRESS

901 Hollins

## 20-UNDERTAKER

John Howard

Specimen of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81948

C81948

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE, No.

1114 Hamburg

ST.:

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Geo. Henry Shamleffer.

(Residence in Baltimore: No.

1114 Hamburg

St.:

70

yrs.,

mos.

ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Sept 2, 1844

(Month)

(Day)

(Year)

7-AGE,

70 yrs. 4 mos. 11 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

Blacksmith

9-BIRTHPLACE,  
(State or Country),

Balt Co, Md

PARENTS.

10-NAME OF FATHER,

Nicholas Shamleffer

11-BIRTHPLACE OF FATHER  
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

C. B. Baskfield

13-BIRTHPLACE OF MOTHER  
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allen Shamleffer

(Address)

1114 Hamburg

JAN 16 1915

Filed

191. Burial Permit. Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 15 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1915, to Jan 15 1915, that I saw him alive on Jan 15 1915, and that death occurred, on the date stated above, at 11<sup>10</sup> P.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Edema

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY  
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

John G. Schumacher

Jan 16, 1915

(Address)

1171 St. Louis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Bachman Cem.

DATE OF BURIAL,

Jan 18, 1915

20-UNDERTAKER

Ed. Cook

ADDRESS

502 E. Madison

Check of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81949

C81949

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

825 W. Bane

ST.;

21

WARD)

REGISTERED NO. C

## 2-FULL NAME

Rosa Zahndrich

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

(8 yrs.) 825 W. Bane

St.; — yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX.

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

## 6-DATE OF BIRTH,

June

12, 1873

(Month)

(Day)

(Year)

## 7-AGE,

41

yrs.

7

mos.

2

ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE, (State or Country),

Baden, Germany

## 10-NAME OF FATHER,

Dont no

## 11-BIRTHPLACE OF FATHER (State or Country),

Dont no

## 12-MAIDEN NAME OF MOTHER

Dont no

## 13-BIRTHPLACE OF MOTHER (State or Country),

Dont no

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Zahndrich

(Address)

825 W. Bane St.

JAN 16 1915

HARRY O. ANDREWS,

Filed.....

1915

Baltimore Health Officer  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan.

14

1915

(Month)

(Day)

(Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

Jan 7

1915

to Jan 14

1915

that I saw her alive on Jan 14

1915

and that death occurred, on the date stated above, at

6 P. M.

## The CAUSE OF DEATH\* was as follows:

Endocarditis

(Duration)....yrs....mos....ds.

## CONTRIBUTORY... (Secondary)

infection

(Duration)....yrs....mos....ds.

(Signed).....

David Sheet M. D.

Jan 15, 1915. (Address).....712 Park Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

Holy Cross Church

## DATE OF BURIAL,

Jan 18, 1915

## 20-UNDERTAKER

Wm Cook

## ADDRESS

302 E. York Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81950

## CERTIFICATE OF DEATH.

C81950

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Church Home St. 70

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Mrs. Emma Winderheim

(Residence in Baltimore: No.

524 N Payson

St.: yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)  
Married

## 6-DATE OF BIRTH,

Feb 16, 1891  
(Month) (Day) (Year)

## 7-AGE,

23 yrs. 11 mos. ds.

If LESS than 1 day,  
...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,  
(State or Country),

Baltimore

## 10-NAME OF FATHER,

George H. Gernoth

11-BIRTHPLACE OF FATHER  
(State or Country),

Pennsylvania

## 12-MAIDEN NAME OF MOTHER

Mary Hiles

13-BIRTHPLACE OF MOTHER  
(State or Country),

Maryland

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles D. Gernoth

(Address) 335 S. Calhoun

15-

JAN 16 1915

HARRY O. ANDREWS,

Filed..... 191... Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 15, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Jan 7 1915, to Jan 15 1915  
that I saw her alive on Jan 14 1915  
and that death occurred, on the date stated above, at 6:00 m.

The CAUSE OF DEATH\* was as follows:

Ulcerating cystitis  
Broncho pneumonia  
(Duration) yrs. mos. ds.  
CONTRIBUTORY (Secondary) Ulcerating cystitis. Pyelo-  
nephrosis (Duration) yrs. mos. ds.  
(Signed) Samuel Starr M. D.  
Jan 15, 1915 (Address) Church Home St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence 524 N Payson St.

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

You Don Park Cem Jan 17, 1915

## 20-UNDERTAKER

## ADDRESS

George A. Farley Sulton &amp; Son

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81951

## CERTIFICATE OF DEATH.

37

C81951

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 7* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *2026 Mc Elderberry St.* St.;

yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Female*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

## 6-DATE OF BIRTH,

*Jan*

(Month)

*15*

(Day)

*1887*

(Year)

## 7-AGE,

*28*

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

## 9-BIRTHPLACE, (State or Country),

*Maryland*

## PARENTS.

## 10-NAME OF FATHER,

*John J. D. Myers*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Washington D.C.*

## 12-MAIDEN NAME OF MOTHER

*Mary L. Baker*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mc Elroy*(Address) *2026 Mc Elderberry St.*

## 15-

Filed

JAN 16 1915

191

HARREY O. ANDREWS,

Bureau of Health

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan*

(Month)

*16*

(Day)

*1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 12 1914* to *Jan 16 1915*, that I saw her alive on *Jan 16 1915*, and that death occurred, on the date stated above, at *1:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Trauma from severe decubital ulceration*

(Duration)

yrs.

*2 1/2*

mos.

da.

## CONTRIBUTORY (Secondary)

*(Heart)*

(Duration)

yrs.

*3 1/2*

mos.

da.

(Signed)

*Melvin Clark M. D.**Jan 16 1915*

(Address)

*14 Mc Elderberry St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

yrs.

mos.

da.

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

*Unknown*

Former or usual residence

*2026 Mc Elderberry St.*

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Baltimore County**Jan 19 1915*

## 20-UNDERTAKER

## ADDRESS

*Christina Miller, 2334 Jefferson St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

64 C81952

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 120 N. Montford Av. ST. 6 WARD)

2 FULL NAME

Annie E. Jaepfner

(Residence in Baltimore: No. 120 N. Montford Av. ST. 6 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

Aug. 29, 1846  
(Month) (Day) (Year)

7 AGE

68 yrs. 4 mos. 15 ds.

If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9 BIRTHPLACE (State or country)

Germany

10 NAME OF FATHER

George Pfoertner

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dorothea Jaepfner

(Address)

120 N. Montford Av.

15

JAN 16 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 9, 1915, to Jan. 13, 1915,

that I saw her alive on Jan. 13, 1915,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia (Hypostatic)

(Duration) yrs. — mos. 5 ds.

Contributory (SECONDARY)

Cerebral Hemorrhage

(Duration) yrs. — mos. 2 ds.

(Signed)

Henry B. Athey, M. D.

1/14, 1915 (Address) 300 N. Park Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

Jan. 17/15, 1915

20 UNDERTAKER

ADDRESS

Christian Miller

2334 Jefferson St.

C81953

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81953

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 N. Rose ST. 6 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 440 N. Rose St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

male

## 4-COLOR OR RACE,

white

## 5-SINGLE,

Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH

September 18, 1850  
(Month) (Day) (Year)

## 7-AGE,

64 yrs. 3 mos. 26 ds.

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...Carpenter9-BIRTHPLACE,  
(State or Country),Balto. Md

## 10-NAME OF FATHER,

Thomas J. Garrett11-BIRTHPLACE OF FATHER  
(State or Country),Balto Co

## 12-MAIDEN NAME OF MOTHER

Susannah Smith13-BIRTHPLACE OF MOTHER  
(State or Country),Balto Md

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Styles(Address) 440 N. Rose St.

15-

JAN 16 1915

Filed

191

MRS. Q. ANDREWS,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 13, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1914, to Jan 13 1915, that I saw h in alive on Jan 13 1915, and that death occurred, on the date stated above, at 2:50 P.m.  
The CAUSE OF DEATH\* was as follows:Exhaustion  
(Duration) yrs. mos. ds.CONTRIBUTORY  
(Secondary)Chronic Bronchitis  
(Duration) yrs. mos. ds.(Signed) Lewis C. BoydJan 14, 1915 (Address) 2601 E. Monument St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Christiana CemeteryJan 16, 1915

## 20-UNDERTAKER

## ADDRESS

John J. Conway Son,901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81954

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C81954

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

Jan 15, 1915 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

JAN 16 1915

Filed

HARRY C. ANDREWS

Serial Permit Clerk

REGISTRAR

UNDERTAKER

R. A. Elliott

ADDRESS

016 East St

PHYSICIANS should  
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION  
is very important. See instructions on back of certificate.

C81955

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C81955

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

Residence in Baltimore: No.

WARD)

(If death occurred in  
a hospital or institution,  
give its NAME instead of  
street and number and  
fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than  
1 day, .... hrs.  
or .... mo. ?

8-OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9-BIRTHPLACE  
(State or country)

10-NAME OF  
FATHER

11-BIRTHPLACE  
OF FATHER  
(State or country)

12-MAIDEN NAME  
OF MOTHER

13-BIRTHPLACE  
OF MOTHER  
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-  
JAN 16 1915

DARREY O. ANDREWS,  
Burial Permit Clerk,  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on  
and that death occurred, on the date stated above, at 3:30 p.m.  
The CAUSE OF DEATH\* was as follows:

Contributory  
(SECONDARY)

(Signed)

1-14, 1915 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place  
of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.  
Where was disease contracted,  
if not at place of death?  
Former or  
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Hampton Jan. 16, 1915  
20-UNDERTAKER  
Chenoweth & Son 3617 Chestnut  
ave



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81956

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH\* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Harry E. Flynn M. D.

Jan 16, 1915 (Address) 3640 Columbia Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs.... mos.... da. In the State.... yrs.... mos.... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Mary's Hospital Jan 18 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Son 3617 Chestnut Ave

15- JAN 16 1915

Filed..... 191... Burial Permit. Clerk Registrar.

C81957

## HEALTH DEPARTMENT—CITY OF BALTIMORE

90

C81957

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2239 McElderry St.*)

REGISTERED NO. C

WARD) *7*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Residence in Baltimore: No. *2239 McElderry*St.; *44* yrs., *...* mos., *...* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Married*

## 6-DATE OF BIRTH

*Nov 14*, *1866*  
(Month) (Day) (Year)

## 7-AGE

*48* yrs., *2* mos., *1* ds.  
If LESS than 1 day, *...* hrs. or *...* min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...*Laborer*  
*Copper works*

## 9-BIRTHPLACE, (State or Country).

*Germany*

## 10-NAME OF FATHER

*Carl Lauskey*

## 11-BIRTHPLACE OF FATHER (State or Country).

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Unknown*

## 13-BIRTHPLACE OF MOTHER (State or Country).

*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaretha Lauskey*(Address) *2239 McElderry*

## 15-

JAN 16 1915  
Filed *...* 191... Burial Permit *...* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

*Jan 15*, *1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Nov 10*, *1914*, to *Jan 15*, *1915*,that I saw him alive on *Jan 15*, *1915*and that death occurred, on the date stated above, at *2:50* m.

The CAUSE OF DEATH\* was as follows:

*Abscess. Lung*  
*(Probably occupational)*  
(Duration) *...* yrs., *...* mos., *...* ds.

## CONTRIBUTORY (Secondary)

*Chronic Bronchitis*  
(Duration) *...* yrs., *...* mos., *...* ds.(Signed) *...* M. D.*...* 191... (Address) *...*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *...* yrs., *...* mos., *...* ds. Is the State *...* yrs., *...* mos., *...* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL

*Oak Lawn*

## DATE OF BURIAL

*Jan 17 1915*

## 20-UNDERTAKER

*Philip Herwig*

## ADDRESS

*2016 Orleans*

Important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificate.

C81958  
JAN 17 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 C81958  
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Carrollton Ave. ST. 16 WARD)

2-FULL NAME Joseph Smith

(Residence in Baltimore: No. 1108 N. Carrollton Ave. St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE Colored 5-SINGLE Married Widowed OR DIVORCED (Write the word) Single

6-DATE OF BIRTH April 10 1885 (Month) (Day) (Year)

7-AGE 29 yrs. 9 mos. 6 ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work Undertaker's helper (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS  
10-NAME OF FATHER William J. Smith  
11-BIRTHPLACE OF FATHER (State or country) Maryland  
12-MAIDEN NAME OF MOTHER Mary A. Thomas  
13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. Morton Chase  
(Address) 1400 Mosher

15- JAN 17 1915 HARRY O. ANDREWS, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan. 14 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 6 1915, to, Jan. 14 1915, that I saw him alive on Jan. 14 1915, and that death occurred, on the date stated above, at 11:35 P. M. The CAUSE OF DEATH\* was as follows:

Acute nephritis with dropsy about 3 mos. ds.

Contributory (SECONDARY) Endocarditis about 1 yr. mos. ds.

(Signed) Chas. L. McCarty M. D. Jan. 16 1915 [Address] 906 N. Strickland

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS



C81959

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C81959

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

## 5-SINGLE,

## MARRIED,

## WIDOWED,

## OR DIVORCED,

## (Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE,

(State or Country),

## 10-NAME OF FATHER,

## 11-BIRTHPLACE OF FATHER

(State or Country),

## 12-MAIDEN NAME OF MOTHER

## 13-BIRTHPLACE OF MOTHER

(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

JAN 17 1915

WERT O. ANDREWS,

Filed

191

Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

(Month)

(Day)

(Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

Nov. 18 1914, to Jan 15 1915,

that I saw him alive on Jan 15 1915,

and that death occurred, on the date stated above, at 5:45 p.m.

## The CAUSE OF DEATH\* was as follows:

Mitral Regurgitation

Duration

Don't know

(Duration) yrs. mos. ds.

## CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward P. Smith M. D.

Jan 15 1915 (Address) Mercy Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 1 mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2400 Fleet St

Former or usual residence 2400 Fleet St

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Mount Carmel Cem.

Jan 17 1915

## 20-UNDERTAKER

## ADDRESS

J. Vander Lons

1700 Fleet St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81960

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

170  
C81960  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 E. Balto ST.; 6 WARD)

2-FULL NAME *Caroline Weigand*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 2810 E. Balto St.; 60 yrs., mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH,

*May 15, 1834*  
(Month) (Day) (Year)

7-AGE,

*81 yrs. 8 mos. ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Weigand*(Address) *2810 E. Balto St.*

15-

JAN 17 1915

HARRY O. ANDREWS,

Filed..... 191... *Barial Permit Clerk*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 15, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 15 1914* to *Jan 15 1915*, that I saw her alive on *Jan 14 1915*, and that death occurred, on the date stated above, at *1315 p. m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Nephritis*(Duration) *10 yrs. mos. ds.*CONTRIBUTORY  
(Secondary)(Duration) *10 yrs. mos. ds.*(Signed) *J. H. Pearson* M. D.*Jan 6 1915* (Address) *2712 N. Calver St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Linden Park*

DATE OF BURIAL,

*Jan. 17, 1915.*

20-UNDERTAKER

*W. Sander & Sons*

ADDRESS

*1710 E. Pratt St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81961

C81961

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2926 E. Pratt* St.; *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

*Emory C. Reeling*Residence in Baltimore: No. *2926 E. Pratt* St.; *1* yrs. *10* mos. *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE,

*White*5-SINGLE, *single*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*March**10**1913*

(Month)

(Day)

(Year)

7-AGE,

*1*

yrs.

*10*

mos.

*6*

ds.

If LESS than 1 day,

hrs.

or

min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

*None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

*Maryland*

10-NAME OF FATHER,

*Leland S. Reeling*

11-BIRTHPLACE OF FATHER

(State or Country),

*Penn.*

12-MAIDEN NAME OF MOTHER

*Amanda H. Wright*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amanda H. Reeling*(Address) *2926 E. Pratt St.*

15-

JAN 17 1915

HARRY O. ANDREWS,

Filed

101

Bureau of Health

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan**16**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan. 15* 1915, to *Jan. 16* 1915, that I saw him alive on *Jan. 16* 1915, and that death occurred, on the date stated above, at *1:30 P.m.*

The CAUSE OF DEATH\* was as follows:

*Diphtheria of Larynx*

(Duration)

*2*

yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)

*2*

yrs. mos. ds.

(Signed)

*Harrison F. Leachman* M. D.*Jan. 16, 1915.* (Address) *2425 St. Paul St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Schwartz Cemetery**Jan. 17, 1915*

20-UNDERTAKER

ADDRESS

*Robert J. Turner**1424 Broadway*

1/2 P. 170.

Check of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81962

C81962

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2209 E. Fayette*ST.: *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Carl Berner*Residence in Baltimore: No. *2209 E. Fayette*St.: *13* yrs., *6* mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Married*

6-DATE OF BIRTH,

*April**26*, *1880*

7-AGE,

*34* yrs., *9* mos., *10* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Engineer*  
*Stationary*9-BIRTHPLACE,  
(State or Country),*Germany*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER  
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Mrs. Berlich*13-BIRTHPLACE OF MOTHER  
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lilly Berner*(Address) *2209 E. Fayette st*

15-

JAN 17 1915

DARBY O. ANDREWS,

Filed..... 191... Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January*, *12*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan. 13*, *1914*, to *Jan. 14*, *1915*,that I saw him alive on *Jan. 14*, *1915*,and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH\* was as follows:

.....

.....

*Pulmonary Tuberculosis*

.....

(Duration) *4* yrs. .... mos. .... ds.CONTRIBUTORY  
(Secondary)

..... (Duration) .... yrs. .... mos. .... ds.

(Signed) *Frank A. Slantz* M. D.*Jan. 15*, *1915*. (Address) *3244 Eastern Ave.*

.....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

.....

.....

19-PLACE OF BURIAL OR REMOVAL,

*Baltimore County*

DATE OF BURIAL,

*Jan. 17*, *1915*.

20-UNDERTAKER

*Christian Miller*

ADDRESS

*233 E. Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81963

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81963

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Duncan ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 514 N. Duncan St.; — yrs., — mos., — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Male

## 4-COLOR OR RACE,

Colored  
a. a

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

## 6-DATE OF BIRTH,

Feb. 1, 1878  
(Month) (Day) (Year)

## 7-AGE,

36 yrs., 11 mos., 14 ds.

If LESS than 1 day,

....hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

## 9-BIRTHPLACE,

(State or Country),

md.

## 10-NAME OF FATHER,

unknown

## 11-BIRTHPLACE OF FATHER

(State or Country),

unknown

## 12-MAIDEN NAME OF MOTHER

Harriet Henson

## 13-BIRTHPLACE OF MOTHER

(State or Country),

md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brown(Address) 514 N. Duncan St.

## 15-

JAN 17 1915

HARRY O. ANDREWS,

FILED

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Dec. 15, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1914, to Jan. 15, 1915, that I saw him alive on Jan. 14, 1915, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation(Duration).... yrs. 5 mos. .... ds.

## CONTRIBUTORY (Secondary)

(Duration).... yrs. .... mos. .... ds.

(Signed) J. C. Robinson, M. D.Jan. 16, 1915 (Address) 611 N. Carroll St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Asbury Cemetery January 18, 1915

## 20-UNDERTAKER

## ADDRESS

Milton Davis, 709 N. Caroline St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.





C81965

## HEALTH DEPARTMENT—CITY OF BALTIMORE

65

C81965

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 E. Preston

ST.: 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. 1514 E. Preston

St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Female

## 4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

## 6-DATE OF BIRTH

October 3rd, 1844  
(Month) (Day) (Year)

## 7-AGE,

70 yrs. 38 mos. 22 ds.

If LESS than 1 day.

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

## 9-BIRTHPLACE,

(State or Country),

Baltimore Md

## 10-NAME OF FATHER,

Martin Hatter

## 11-BIRTHPLACE OF FATHER

(State or Country),

Germany

## 12-MAIDEN NAME OF MOTHER

Fredericka Lentz

## 13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Hardeste

(Address) 1514 E. Preston St

## 15-

JAN 17 1915

HARRY O. ANDREWS

Filed 1915 Serial Permit 419

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 8, 1915, to Jan 10, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1915, to Jan 10, 1915, that I saw her alive on Jan 10, 1915, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

(Duration) 2 yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) 4 yrs. mos. ds.

(Signed) Benjamin S. Hardeste M. D.

Jan 15, 1915. (Address) 1216 N. Caroline St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Greenmount Cemetery Jan 17, 1915

## ADDRESS

John B. Spence 1325 N. Caroline St

GROUP OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81966

C81966

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *19* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *5-13 N. Guilmore St.* yrs. mos. ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE,  
MARRIED, *Married*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Aug* —, *1864*  
(Month) (Day) (Year)

## 7-AGE,

*60* yrs. *5* mos. — ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,  
(State or Country),*Maryland*

## 10-NAME OF FATHER,

*Henry H. North*11-BIRTHPLACE OF FATHER  
(State or Country),*Maryland*

## 12-MAIDEN NAME OF MOTHER

*Sarah Horner*13-BIRTHPLACE OF MOTHER  
(State or Country),*Maryland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Winter D. North Jr.*(Address) *1505 W. Lammale St.*

## 15-

JAN 17 1915  
Filed..... 191.....  
HARRY O. ANDREWS,  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* *15*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 13* 1915, to *Jan 15* 1915; that I saw him alive on *Jan 15* 1915; and that death occurred, on the date stated above, at *7:05 pm.*

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*(Duration)..... yrs. mos. *3* ds.CONTRIBUTORY  
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *B. H. Quistad* M. D.*1-15-15*, 1915. (Address) *University Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. *3* ds. In the State *60* yrs. — mos. — ds.Where was disease contracted, if not at place of death? *Petersen T. Graves Lunch*Former or usual residence *5-13 N. Guilmore St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Mount Olivet*

## DATE OF BURIAL,

*Jan. 17*, 1915.

## 20-UNDERTAKER

*E. M. Mitchell*

## ADDRESS

*120 W. Fayette St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81967

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81967

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *1834 Hope St.*  
 CITY OF BALTIMORE: (No. *1834 Hope* ST.; *9* WARD)  
 2-FULL NAME *Louis Rudolf Bohlner*  
 Residence in Baltimore: No. *1834 Hope St.* St.; *53* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*  
 4-COLOR OR RACE, *white*  
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*  
 (Write the word.)  
 6-DATE OF BIRTH, *29 April, 1861*  
 (Month) (Day) (Year)  
 7-AGE, *53* yrs., *8* mos., *18* ds.  
 If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work, *House-Maker*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Austria*

10-NAME OF FATHER, *Engelbert Bohlner*  
 11-BIRTHPLACE OF FATHER (State or Country), *Austria*  
 12-MAIDEN NAME OF MOTHER, *unknown*  
 13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mr. Anne Bohlner, wife*  
 (Address), *1834 Hope St.*

15- *JAN 17 1915* *DANNY O. ANDREWS,*  
 Filed..... 191.. *Bureau Permit Clerk*  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan. 16, 1915*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 15, 1914*, to *Jan. 16, 1915*, that I saw him alive on *Jan. 16, 1915*, and that death occurred, on the date stated above, at *2:30 p.m.*  
 The CAUSE OF DEATH\* was as follows:

*Apoplexy*  
 (Duration)..... yrs..... mos..... ds.  
 CONTRIBUTORY... *Thrombosis cerebralis*.....  
 (Secondary)  
 (Duration)..... yrs..... mos..... ds.  
 (Signed)..... M. D.  
*Jan. 16, 1915* (Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *Jan. 17, 1915*

20-UNDERTAKER, *M. Cook* ADDRESS, *North Green St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81968

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81968

## CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. *Municipal Hospital* ST.; *4* WARD)2. FULL NAME *Mr E Carr*Residence in Baltimore: No. *W Airy Md* St.; *70* yrs., *16* mos. *16* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)3-DATE OF BIRTH, *Unknown, 1845* (Month) (Day) (Year)7-AGE, *70* yrs. - *16* mos. - *16* ds. If LESS than 1 day, *hrs. or min.*8-OCCUPATION: (a) Trade, profession, or particular kind of work *Farmer* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *James Carr*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Elizabeth Haynes*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George M Carr*(Address) *W Airy Md*

15- JAN 17 1915 HARRY O. ANDREWS,

Filed *1915* Serial Permit *Clark* Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 16, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 9 1915*, to *Jan 16 1915*, that I saw him alive on *Jan 16 1915*, and that death occurred, on the date stated above, at *6.30 am*.

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(Duration) *1* yrs. *7* mos. *16* ds.CONTRIBUTORY (Secondary) *Myocarditis*(Duration) *7* yrs. *7* mos. *16* ds.(Signed) *B. H. Christy* M. D.*1-16, 1915* (Address) *Municipal Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *7* yrs. *16* mos. *16* ds. In the *70* yrs. *16* mos. *16* ds.Where was disease contracted, if not at place of death? *W Airy Md*Former or usual residence *W Airy Md*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Quince Bridge* *Jan 19, 1915*20-UNDERTAKER ADDRESS *William Cook* *507 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

81969

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

REGISTERED NO. C

81 81969

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Whitelock St. 16 WARD)

2-FULL NAME Rebecca Baer.

(Residence in Baltimore: No. 1112 Whitelock St. 36 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Jan 17, 1915 (Month) (Day) (Year)

7-AGE 93 yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Russia

10-NAME OF FATHER Solomon Baer

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Eva Solomon

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Lewis

(Address) 1419 E. Baltimore

15-JAN 17 1915 HARRY O. ANDREWS, Registrar

Filed Jan 17 1915 Burial Permit Clerk

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan 17, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1915, to Jan 17, 1915, that I saw her alive on Jan 16, 1915, and that death occurred, on the date stated above, at 9A m. The CAUSE OF DEATH\* was as follows:

Arterio-sclerosis

(Duration) 10 yrs. mos. ds.

Contributory Exhaustion - cardiac collapse

(Signed) J. Frederick Leitz M. D.

Jan 17, 1915 (Address) 2040 E. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted? If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Washington 1/17, 1915

20-UNDERTAKER Frank Lewis ADDRESS 1419 E. Baltimore

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81970

## CERTIFICATE OF DEATH.

REGISTERED NO. C

39 C81970

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hsp.* ST. 7 WARD)FULL NAME *James A. Stewart*(Residence in Baltimore: No. *1200 Princess St. Alexandria, Va.* St.; ..... yrs., ..... mos., ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

*Male*

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

*Feb. 12, 1874*  
(Month) (Day) (Year)

7-AGE.

*71* yrs., ..... mos., ..... ds.

If LESS than 1 day.

.... hrs. or .... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Engineer*(b) General nature of industry, business, or establishment in which employed (or employer). *Locomotive*

9-BIRTHPLACE, (State or Country).

*New York*

PARENTS.

10-NAME OF FATHER.

*John A. Stewart*

11-BIRTHPLACE OF FATHER (State or Country).

*Indiana*

12-MAIDEN NAME OF MOTHER.

*John A. Stewart*

13-BIRTHPLACE OF MOTHER (State or Country).

*Indiana*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. J. Phelps*(Address) *Johns Hopkins Hsp.*

15-

Filed *JAN 17 1915*

HARRY O. ANDREWS,

Bureau Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Jan. 17, 1915*  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Dec. 12, 1914* to *Jan. 17, 1915*.that I saw him alive on *Jan. 17, 1915*.and that death occurred, on the date stated above, at *8:10* a.m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary embolism*

..... (Duration) ..... yrs., ..... mos., ..... ds.

CONTRIBUTORY (Secondary) *Pneumonia*

..... (Duration) ..... yrs., ..... mos., ..... ds.

(Signed) *James A. Stewart* M. D.*Jan. 17, 1915* (Address) *Johns Hopkins Hsp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs., ..... mos., ..... ds. In the State ..... yrs., ..... mos., ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1200 Princess St. Alexandria*

19-PLACE OF BURIAL OR REMOVAL.

*Alexandria, Va.*DATE OF BURIAL *Jan. 17, 1915*

20-UNDERTAKER

*Alfred C. Fuller*ADDRESS *321 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81971

C81971

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 943 Stirling

ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Maggie L. Harbo

(Residence in Baltimore: No. 943 Stirling

St.: 32 yrs., 11 mos., 13 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

Female

## 4-COLOR OR RACE,

White

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

## 6-DATE OF BIRTH,

February 3, 1882  
(Month) (Day) (Year)

## 7-AGE,

32 yrs., 11 mos., 13 ds.

If LESS than 1 day.

...hrs. or...min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

## 9-BIRTHPLACE, (State or Country),

Balt. Md.

## 10-NAME OF FATHER,

John Barrier

## 11-BIRTHPLACE OF FATHER (State or Country),

Balt. Md.

## 12-MAIDEN NAME OF MOTHER

Elizabeth Greenwich

## 13-BIRTHPLACE OF MOTHER (State or Country),

Balt. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Williams, J. Harbo

(Address)

929 E. Eager St.

15- JAN 18 1915.

ROBERT J. KRAUTER

Filed..... 191... Burial Permit Clerk.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan 16, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1915, to Jan 16, 1915, that I saw her alive on Jan 10, 1915, and that death occurred, on the date stated above, at 1:20, m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(Duration)..... yrs. 4 mos. ds.

## CONTRIBUTORY (Secondary)

(Signed) W. J. Kelly M. D.  
Jan 16, 1915. (Address) 1923 N. North Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Holy Redeemer Cemetery

Jan. 20, 1915.

## 20-UNDERTAKER

## ADDRESS

Harry Hooker

1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## PLACE OF DEATH

CITY OF BALTIMORE: (No. *1526 N. Durham*ST.: *8*

WARD)

REGISTERED NO. C

FULL NAME *Lawrence M. Sherman*(Residence in Baltimore: No. *1526 N. Durham*

St.: ..... yrs. .... mos. .... da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE,

*White*

## 5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.) *Single*

## 6-DATE OF BIRTH,

*Dec.**10**1914*

(Month)

(Day)

(Year)

## 7-AGE,

*1**7**da.*

If LESS than 1 day.

..... hrs. or ..... min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*

## 9-BIRTHPLACE,

(State or Country),

*Balto. Md.*

## 10-NAME OF FATHER,

*Robert M. Sherman*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Balto. Md.*

## 12-MAIDEN NAME OF MOTHER

*Jennie M. Street*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Va.*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Robert M. Sherman*(Address) *1526 N. Durham*

JAN 18 1915

ROBERT M. KRAUTER,

Filed.....

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*January*

(Month)

*17*

(Day)

*1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec. 29* 191*4*, to *January 17* 191*5*, that I saw him alive on *January 16* 191*5*, and that death occurred, on the date stated above, at *29* m.

The CAUSE OF DEATH\* was as follows:

*Marasmus*

## CONTRIBUTORY (Secondary)

(Duration)

*1**mos.**da.*(Signed) *H. Austin**Del. Ave.**M. D.*Jan. 17, 1915. (Address) *2250 E. Hoffman St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Baltimore Cemetery*

## DATE OF BURIAL,

*Jan. 19, 1915*

## 20-UNDERTAKER

*Henry Brock & Son*

## ADDRESS

*1301 E. Gay*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

30 C81973

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaret Anna Fuchs*(Residence in Baltimore: No. *1955 N. Collington* ave. St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *March* *16*, *1911*  
(Month) (Day) (Year)7-AGE, *3* yrs. *10* mos. *10* da. If LESS than 1 day, hrs. or min.8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. *nurse*  
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Balto. Co. Md*10-NAME OF FATHER, *Frank Fuchs*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Mary G. Chamberlain*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Frank Fuchs*(Address) *1955 N. Collington Ave*15- *JAN 18 1915* *ROBERT KRAUTER*Filed *Burial Permit Clerk*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January* *16*, *1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 9* 1915, to *Jan 16* 1915, that I saw her alive on *Jan 16* 1915, and that death occurred, on the date stated above, at *5:30 P.* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Meningitis*(Duration) yrs. mos. *10* ds.CONTRIBUTORY (Secondary) *Myocarditis*(Duration) yrs. mos. *4* ds.(Signed) *H. H. Warner* M. D.*Jan 16, 1915* (Address) *St. Josephs Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *1955 N. Collington Ave.*Former or usual residence *1955 N. Collington Ave.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, *Jan 19, 1915**Holy Redeemer Cemetery*

20-UNDERTAKER

*Henry Brock Sen*ADDRESS *1301 E Eager St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81974

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81974

## CERTIFICATE OF DEATH.

50  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 N. Eden ST.; 10 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1032 N. Eden

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 66 yrs., 3 mos., 2 ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

Male

## 4-COLOR OR RACE,

White

## 5-SINGLE,

MARRIED,

WIDOWER,

OR DIVORCED,

(Write the word.)

Single

## 6-DATE OF BIRTH

September 24, 1848  
(Month) (Day) (Year)

## 7-AGE,

66 yrs., 3 mos., 12 ds.

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Book binder

9-BIRTHPLACE,  
(State or Country),

Baltimore Md.

## 10-NAME OF FATHER,

George M. Brooks

11-BIRTHPLACE OF FATHER  
(State or Country),

Washington D.C.

## 12-MAIDEN NAME OF MOTHER

Teresa M. Butler

13-BIRTHPLACE OF MOTHER  
(State or Country),

Stafford Co. Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel M. Brooks

(Address)

1032 N. Eden St.

## 15-

JAN 18 1915

ROBERT KRAUTER,

Filed

191

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 16, 1915.  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1914, to Jan. 16, 1915, that I saw him alive on Jan. 15, 1915, and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH\* was as follows:

Diabetes

Uncertain

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Edwin B. Fenty, M. D.

Jan. 16, 1915. (Address) 1223 N. Lardine St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

St. Mary's Cemetery, Baltimore, Md.

Jan. 17, 1915.

## 20-UNDERTAKER

Henry H. Hark

## ADDRESS

1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81975

91 C81975

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH  
 CITY OF BALTIMORE: (No. *927 N. Edgewood* ST.; *10* WARD) REGISTERED NO. C  
 (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
 2-FULL NAME *Josefido A. Zug*  
 (Residence in Baltimore: No. *1927 N. Edgewood* St.; *1* yrs., *1* mos., *6* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*  
 6-DATE OF BIRTH, *November 20*, 1915  
 (Month) (Day) (Year)  
 7-AGE, *1* yrs., *1* mos., *26* ds. If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work *miner*  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

## 9-BIRTHPLACE, (State or Country),

*1 Balto. Md*

## PARENTS.

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), *1 Phila. Pa.*

## 12-MAIDEN NAME OF MOTHER

*Maria K. Buckale*

13-BIRTHPLACE OF MOTHER (State or Country), *Phila. Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Joseph Zug*(Address) *927 N. Edgewood*

15- JAN 18 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 16*, 1915  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 6* 1915, to *Jan 16* 1915, that I saw him alive on *Jan 16* 1915, and that death occurred, on the date stated above, at *79* m.  
 The CAUSE OF DEATH\* was as follows:

*1 French pneumonia*(Duration) .... yrs. .... mos. *10* ds.

## CONTRIBUTORY (Secondary)

*1st Farther*  
 (Duration) .... yrs. .... mos. .... ds.  
 (Signed) *E. O. Kellum* M. D.  
*Jan 16* 1915. (Address) *144 E. Eager St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

## 19-PLACE OF BURIAL OR REMOVAL,

*Holy Redeemer Cemetery*

## DATE OF BURIAL,

*Jan 18*, 1915

## 20-UNDERTAKER

*Henry Horck Son*

## ADDRESS

*1301 E Eager St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT-CITY OF BALTIMORE

C81976

## CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

127 Asquith St.

CITY OF BALTIMORE (No.

127 Asquith St.

ST. 5 WARD)

2-FULL NAME

Abraham Gredalen

Residence in Baltimore: No.

127 Asquith St.

St. 9 yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

married

6-DATE OF BIRTH

unknown, 1841  
(Month) (Day) (Year)

7-AGE

74 yrs. mos. ds. or min. 7  
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE  
(State or country)

Russia

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER  
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER  
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. S. Gredalen

(Address)

127 Asquith St.

JAN 18 1915

Filed

191

ROBERT S. GRAUTES,

Burial Permit Clerk,

REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

January 7, 1915  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

15th January, 1915, to 17th January 1915.

that I saw him alive on January 17, 1915.

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Apoplexy

Contributory  
(SECONDARY)

(Duration) yrs. mos. ds.  
Paralysis Respiratory  
Heart.

(Signed)

Henry S. Gredalen, M. D.

Jan 17, 1915 (Address) 1610 E. 73rd Street

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

127 Asquith St.

19-PLACE OF BURIAL OR REMOVAL

John Henry Bur Jan 18, 1915

20-UNDERTAKER

S. L. Linnson & Co Balto St

DATE OF BURIAL

Jan 18, 1915

ADDRESS

1107 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

c.—5-19-13—M. & T.—500 Bks.

C81977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hebrew Hospital*

CITY OF BALTIMORE: (No. *Mount* ST.; *3* WARD)

2-FULL NAME *M. Hyman Libovitz*

(Residence in Baltimore: No. *1011 E Lombard St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

St.; *19* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*male*

4-COLOR OR RACE,

*white*

5-STATUS,

*MARRIED, widow*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*January* *17*, *1930*  
(Month) (Day) (Year)

7-AGE,

*85* yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Russia*

10-NAME OF FATHER, *Labil Libovitz*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Libovitz*

(Address) *1011 E Lombard St.*

15-

*JAN 18 1915* *ROBERT KRAUTER*  
Filed *191* *Burial Permit Clerk*  
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January* *17*, *1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*January 15 1915*, to *Jan 17* *1915*,

that I saw him alive on *Jan 17* *1915*,

and that death occurred, on the date stated above, at *6:54* m.

The CAUSE OF DEATH\* was as follows:

*Cancer of esophagus*  
*preformed by pneumonia*  
*for admission to Hebrew Hospital*  
(Duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yr. — mos. — ds.

(Signed) *M. B. Levine* M. D.

*1/17*, *1915* (Address) *Hebrew Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *2* ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? *109 Asquith St*

Former or usual residence *1011 E Lombard St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Hebrew Home Bur* *Jan 15, 1915*

20-UNDERTAKER

ADDRESS *1107 E*

*S. L. Linscott Bur Balto St*





16. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

081979

159

081979

PLACE OF DEATH  
CITY OF BALTIMORE (No. 1030 N. STRICKER ST. ST. 16 WARD)  
2-FULL NAME HORATIO S. MINER,  
(Residence in Baltimore: No. 1030 N. STRICKER ST. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)  
6-DATE OF BIRTH, October 11th, 1862. (Month) (Day) (Year)  
7-AGE, 52 yrs. 3 mos. 4 ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work. Canvasser for  
(b) General nature of industry, business, or establishment in which employed (or employer). household specialties.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Joseph C. Miner,

11-BIRTHPLACE OF FATHER, (State or Country), Connecticut,

12-MAIDEN NAME OF MOTHER, Sarah McGowan,

13-BIRTHPLACE OF MOTHER, (State or Country), Pennsylvania,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Mary E. Robinson, sister,  
(Address) 1030 N. Stricker st.

15- JAN 18 1915 ROBERT KRAUTER, Registrar.  
Filed, 191. Burial Permit Clerk

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 15th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.  
The CAUSE OF DEATH\* was as follows:

PISTOL-SHOT WOUND OF HEAD, (SUICIDE)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) Frederick Hempel, M. D. (Coroner)  
Jan. 16, 1915. (Address) 1103 Valley st.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
At place In the  
of death ....yrs. ....mos. ....ds. State ....yrs. ....mos. ....ds.  
Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, London Park by Jan. 18th, 1915.  
20-UNDERTAKER, ADDRESS Stewart & Monro 108 W. North St.



C81980

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81980

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home + Infirmary* 6E REGISTERED NO. C  
 CITY OF BALTIMORE: (No. *Church Home + Infirmary* ST.; *6E* WARD)  
 2-FULL NAME *Miss Katie Birkner*  
 (Residence in Baltimore: No. *512 Oakley Road - Gorman, Ind.* St.; *6E* yrs., *6E* mos., *6E* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*  
 6-DATE OF BIRTH, *August 24th*, 18*75*  
 (Month) (Day) (Year)  
 7-AGE, *39* yrs., *4* mos., *24* ds. If LESS than 1 day, ....hrs. or....min.

8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work. *Companion*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *"*

9-BIRTHPLACE, (State or Country), *Baltimore, Maryland*

10-NAME OF FATHER, *Edward Kirkner*  
 11-BIRTHPLACE OF FATHER (State or Country), *Baltimore, Md.*  
 12-MAIDEN NAME OF MOTHER *Rathene Schmidt*  
 13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
 (Informant) *J. H. Burton Jr.*  
 (Address) *Gorman Ind.*

15- *JAN 18 1915* ROBERT . KRATZER, Registrar.  
 Filed....., 191... *Burial Permit Clerk*

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 17, 1915*  
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Jan 8th* 1915, to *Jan 17* 1915, that I saw her alive on *Jan 17* 1915, and that death occurred, on the date stated above, at *10<sup>30</sup>* m.  
 The CAUSE OF DEATH\* was as follows:

*Myocardial Insufficiency*  
*Carcinoma of Rectum*  
 (Duration) yrs. *3* mos. *3* ds.  
 CONTRIBUTORY *Post-operative shock*  
 (Secondary) (Duration) yrs. *3* mos. *3* ds.  
 (Signed) *W. H. Starr* M. D.  
*Jan 17, 1915* (Address) *Church Home + Infirmary*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).  
 At place of death yrs. *10* mos. *10* ds. In the State yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death? *Not known*  
 Former or usual residence *512 Oakley Road - Gorman Ind.*

19-PLACE OF BURIAL OR REMOVAL, *Mount Ridge Cemetery* DATE OF BURIAL, *Jan 19, 1915*  
 20-UNDERTAKER, *Stewart Mason Company* ADDRESS *10820 North St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH,

## 7-AGE,

If LESS than 1 day.

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.  
(b) General nature of industry, busi-  
ness, or establishment in which  
employed (or employer).9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- JAN 18 1915

Filed..... 191.....

ROBERT

. ZRAUTER

Baptist Church  
Registrar.

## 16-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

## UNDERTAKER

## ADDRESS

REGISTERED NO. C

(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number and  
fill out No. 18.)

St.: yrs. mos. ds.)

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from  
that I saw him alive on  
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

(Duration) no. yrs. no. mos. ds.

CONTRIBUTORY  
(Secondary)

(Duration) no. yrs. no. mos. ds.

(Signed) M. D.

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL.

## UNDERTAKER

## ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *1571 S. Eager* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1571 S. Eager* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Married*

6-DATE OF BIRTH *Feb 9* 18*86*  
(Month) (Day) (Year)

7-AGE *58* yrs. *10* mos. ds. or min. *1* day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balt City*

10-NAME OF FATHER *Michael Bersick*

11-BIRTHPLACE OF FATHER (State or country) *France*

12-MAIDEN NAME OF MOTHER *Mary Wittenauer*

13-BIRTHPLACE OF MOTHER (State or country) *France*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry Faibe*

(Address) *1571 S Eager st.*

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Jan 16* 19*15*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 21*, 19*14*, to, *Jan 16*, 19*15*, that I saw her alive on *Jan 16*, 19*15*, and that death occurred, on the date stated above, at *10 P* m. The CAUSE OF DEATH\* was as follows:  
*Diseases Multiple*

Contributory (SECONDARY)

(Signed) *Chas. B. L...* M. D.  
191... [Address] *830 N Broadway*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Holy Redeemer Jan 19* 19*15*

20-UNDERTAKER ADDRESS

*A. Pink & Son 915 N. Gay St.*

15- *JAN 18 1915* *ROBERT KRAUTER* *Serial Permit Clerk* REGISTRAR

C81983

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81983

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No.

St.; 0 yrs., 3 mos. — ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

15-

JAN 18 1915

Filed

191

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

(Bronch) Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

18-Signed

Jan 18, 1915

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C81984

## CERTIFICATE OF DEATH.

155 C81984

### PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *24* WARD)

### FULL NAME

(Residence in Baltimore: No. *1456 Stevenson St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

*Male*

4-COLOR OR RACE

*White*

5-MARRIED

*Single*

6-DATE OF BIRTH

*January*

*28, 1858*

7-AGE

*56*

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Farmer*

9-BIRTHPLACE

(State or Country)

*Prussia*

10-NAME OF FATHER

*August Knopf*

11-BIRTHPLACE OF FATHER

(State or Country)

*Germany*

12-MAIDEN NAME OF MOTHER

*Josephine Klaus*

13-BIRTHPLACE OF MOTHER

(State or Country)

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Apollonia Koller*

(Address)

*208 N. Dolphin St.*

15

JAN 18 1915

Filed

191

SENER 10, TRAFFIC

Burial Permit Clerk

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*January*

*15, 1915*

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

(Inquest, at

death on the day stated above.

The CAUSE OF DEATH was as follows:

*Suicide - Shot by himself*

(Duration)

yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs. mos. ds.

(Signed)

*W. H. Chambers* M. D.

(Coroner)

*Jan 12, 1915* (Address) *18 N. Franklin St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

In the

yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

For or usual residence

PLACE OF BURIAL OR REMOVAL

*St. Alphonsus*

DATE OF BURIAL

*Jan 19, 1915*

UNDERTAKER

*Wm. Boon*

ADDRESS

*307 E. N. Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

081985

HEALTH DEPARTMENT—CITY OF BALTIMORE

081985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 14 E 20 St.)

2-FULL NAME

(Residence in Baltimore: No. 14 E 20 St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

negro

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Jan 18, 1828

7-AGE,

87

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JAN 18 1915

Filed

191

ROBERT

KRAUTER

Bureau

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 16, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Organic Heart Disease

(Duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. da.

(Signed) J. B. Pye, M.D.

(Coroner.)

Address: 364 N. ...

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. .... mos. .... da. In the State.... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn Cemetery

Jan 19, 1915

20-UNDERTAKER

Helix B. Pye.

ADDRESS

102 E. Mulberry St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81986

HEALTH DEPARTMENT—CITY OF BALTIMORE

C81986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

706 1/2 W Saratoga

Olinor Bonds

706 1/2 W Saratoga

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JAN 18 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Felix B. Pye

102 E. Mulberry St.

C81987

## HEALTH DEPARTMENT—CITY OF BALTIMORE

154

C81987

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hillen Road*  
 CITY OF BALTIMORE: (No. *Lake Montebello* ST. *9* WARD)  
 2-FULL NAME *Thomas Armstrong*  
 (Residence in Baltimore: No. *Lake Montebello Hillen Road* St. *2* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*  
 6-DATE OF BIRTH, *October 27<sup>th</sup>, 1880*  
 (Month) (Day) (Year)  
 7-AGE, *34* yrs. *2* mos. *20* ds. If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:  
 (a) Trade, profession, or particular kind of work *Retired*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Newark N. J.*

10-NAME OF FATHER, *Thomas Armstrong*  
 11-BIRTHPLACE OF FATHER (State or Country), *Ireland*  
 12-MAIDEN NAME OF MOTHER *Isabel Buchanan*  
 13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
 (Informant) *James W. Armstrong*  
 (Address) *Hillen Road at Lake Montebello*

15- *JAN 18 1915*  
 Filed *ROBERT A. TRAUTER*  
 Registrar

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 16<sup>th</sup>, 1915*  
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 15<sup>th</sup>, 1915*  
 191 *Jan 15<sup>th</sup>, 1915*  
 that I saw him alive on *Jan 15<sup>th</sup>, 1915*  
 and that death occurred, on the date stated above, at *2:30 a.m.*

The CAUSE OF DEATH\* was as follows:  
*Gradual failure of all organs from age.*  
*Not marked for post - yrs. 2 mos. ds.*

CONTRIBUTORY (Secondary).....

(Signed) *E. H. Wan* M. D.  
*Jan 17<sup>th</sup>, 1915* (Address) *202 W. 17<sup>th</sup> St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *Jan 18<sup>th</sup>, 1915*

20-UNDERTAKER *George Schilling & Sons* ADDRESS *1126 E. Monument*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81988

C81988

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garrett Hospital for Children* ST.; *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *3127 Fleet St* St.; *7* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

*Male*

## 4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

## 6-DATE OF BIRTH,

*Aug 3*, 1907  
(Month) (Day) (Year)

## 7-AGE,

*7* yrs. *5* mos. *14* ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

## 9-BIRTHPLACE, (State or Country),

*Balto Md.*

## 10-NAME OF FATHER,

*Bertus Ebelke*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Germany*

## 12-MAIDEN NAME OF MOTHER

*Anna Dieterich*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W.C. Bacon*(Address) *Garrett Hospital*

## 15-

JAN 18 1915  
Filed

ROBERT TRAUBER

Burial Record Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan* *17*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 30* 1914, to *Jan 17* 1915, that I saw him alive on *Jan 17* 1915, and that death occurred, on the date stated above, at *7.15* a.m.

The CAUSE OF DEATH\* was as follows:

*Chorea*(Duration) *2* yrs. *18* mos. *18* ds.CONTRIBUTORY (Secondary) *Endo Carditis*(Duration) *2* yrs. *18* mos. *18* ds.(Signed) *Walter C. Bacon* M. D.1/17/15, 1915 (Address) *Garrett Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *18* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *3127 Fleet St.*Former or usual residence *3127 Fleet St.*

## 19-PLACE OF BURIAL OR REMOVAL,

*Trinity Cemetery*

## DATE OF BURIAL,

*Jan 20, 1915.*

## 20-UNDERTAKER

*H. Sander & Sons 1710 Fleet St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81989

## CERTIFICATE OF DEATH.

132 C81989

1-PLACE OF DEATH

University Hosp

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Fondaco Greene St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Nellie Kairus

(Residence in Baltimore: No.

873 Hollen

St.; 30 yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1877

7-AGE,

38

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Housewife

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF  
FATHER,

Gen. Lepinitis

11-BIRTHPLACE  
OF FATHER  
(State or Country),

Russia

12-MAIDEN NAME  
OF MOTHER

Elizaveta Gerasimovna

13-BIRTHPLACE  
OF MOTHER  
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

See above

(Address)...

873 Hollen

15-

ROBERT J. TRAFTER,

JAN 18 1915

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 16, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Jan 13 1915, to Jan 16, 1915,

that I saw her alive on Jan 16, 1915,

and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH\* was as follows:

Felice Peritonitis

(Duration)....yrs....mos....ds.

CONTRIBUTORY

(Secondary)

(Duration)....yrs....mos....ds.

(Signed) M. L. Lechman, M. D.

Jan 16, 1915 (Address) University Hosp

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State 19 yrs. mos. ds.

Where was disease contracted, if not at place of death? 873 Hollen St.

Former or usual residence Former residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Jan 19, 1915

20-UNDERTAKER

ADDRESS

John Gebliackas 500 S. Race St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 Altmark

ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 31 Altmark St

St.: 2 yrs., 8 mos. 4 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JAN 18 1915

ROBERT J. BRANTZ,

Municipal Health Officer

Filed 1915

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

(Address) 165 Brady

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent Cemetery

Jan. 18, 1915.

20-UNDERTAKER

ADDRESS

W. J. Schaeffer &amp; Son 8 S. Front St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

92 C81991  
REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115 Bunnery* ST. *1* WARD)

## 2-FULL NAME

(Residence in Baltimore: No. *1115 Bunnery*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *50* yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Female*

## 4-COLOR OR RACE

*White*

## 5-SINGLE,

*MARRIED, Widowed*  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

*Unknown*, *1856*  
(Month) (Day) (Year)

## 7-AGE,

*58*

If LESS than 1 day,

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

## 9-BIRTHPLACE,

(State or Country),

*Ireland*

## 10-NAME OF FATHER,

*Thomas Elwood*

## 11-BIRTHPLACE OF FATHER

(State or Country),

*Ireland*

## 12-MAIDEN NAME OF MOTHER

*Ann Bannon*

## 13-BIRTHPLACE OF MOTHER

(State or Country),

*Ireland*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas Ledwith*(Address) *1115 Bunnery St.*

## 15-

ROBERT KRAUTER,

Filed

JAN 18 1915

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 16*, *1915*  
(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

*Jan 13*, *1915*, to *Jan 16*, *1915*,that I saw her alive on *Jan 16*, *1915*,and that death occurred, on the date stated above, at *1030 a* m.

The CAUSE OF DEATH\* was as follows:

*Tubercular Pneumonia*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *V. B. Titlow* M. D.*Jan 16*, *1915* (Address) *303 V. O'Donnell*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

*Cath Law - Cem.**Jan 18*, *1915*.

## 20-UNDERTAKER

## ADDRESS

*Lilly Geiler**403 S. Volpe*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



C81992

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C.

## PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N. Durham ST.; 7 WARD)

## FULL NAME

Elias Stockett(Residence in Baltimore: No. 725 N. Durham

St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 1-SEX,

male

## 4-COLOR OR RACE,

col.5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)  
widow

## 6-DATE OF BIRTH,

Sept. 30, 1838  
(Month) (Day) (Year)

## 7-AGE,

76 yrs. 4 mos. da.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),Md.

## 10-NAME OF FATHER,

Elijah Stockett11-BIRTHPLACE OF FATHER  
(State or Country),Md.

## 12-MAIDEN NAME OF MOTHER

unknown13-BIRTHPLACE OF MOTHER  
(State or Country),Md.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Miller(Address) 725 N. Durham St.15-  
JAN 18 1915

ROBERT KRAUTER,

Filed 1915 Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

Jan. 14, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Dec. 28, 1914, to Jan. 14, 1915,  
that I saw him alive on Jan. 14, 1915,  
and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. da.

CONTRIBUTORY  
(Secondary)Hemiplegia (Duration) 2 yrs. 2 mos. da.(Signed) R. K. Krauter M. D.Jan. 14, 1915 (Address) 611 N. Caroline St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

National cemetery Jan. 18, 1915

## 20-UNDERTAKER

## ADDRESS

R. B. Gross 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1617 Rosedale* ST.; *16* WARD)2. FULL NAME *Frederick J. Volz*(Residence in Baltimore: No. *1617 Rosedale* St.; *Lifetime* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Dec 30<sup>th</sup> 1855*

(Month)

(Day)

(Year)

7-AGE, *59* yrs., *27* mos., ds.

If LESS than 1 day, .... hrs. or .... min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Polisher*(b) General nature of industry, business, or establishment in which employed (or employer). *F. H. Ganter*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *George Volz*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Wilhelmina Schmidt*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary J. Volz*(Address) *1617 Rosedale St*15-**JAN 18 1915**

Filed..... 191

ROBERT J. KRAUTER  
Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 16<sup>th</sup> 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb. 1* 191*4*, to *Jan. 16* 191*5*, that I saw him alive on *Jan. 15* 191*5*, and that death occurred, on the date stated above, at *5:45* a.m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*  
(Duration) *2* yrs., mos., ds.

## CONTRIBUTORY (Secondary)

(Signed) *Henry H. Hirschman, M.D.*  
*Jan. 17 1915* (Address) *933 N. Broadway*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cemetery*DATE OF BURIAL, *Jan. 18, 1915*ADDRESS *Mr. & Mrs. John H. Tengel, 80 N. Fayette St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE, C81994

## CERTIFICATE OF DEATH.

PLACE OF DEATH *Johns Hopkins Hosp.* REGISTERED NO. C *x 176*  
 CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)  
 FULL NAME *Thomas A. 7th St.*  
 (Residence in Baltimore: No. *Mason. N.C.* St. *7* yrs. *7* mos. *16* ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*  
 6-DATE OF BIRTH *Unknown*, 1861 (Month) (Day) (Year)  
 7-AGE *54* yrs. *5* mos. *4* ds. If LESS than 1 day, .... hrs. or .... min.  
 8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Merchant* (b) General nature of industry, business, or establishment in which employed (or employer) *Merchant*

9-BIRTHPLACE, (State or Country), *N. C.*

10-NAME OF FATHER *Unknown*  
 11-BIRTHPLACE OF FATHER (State or Country), *Unknown*  
 12-MAIDEN NAME OF MOTHER *Sarah Aiken*  
 13-BIRTHPLACE OF MOTHER (State or Country), *N. C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *O. Phelps*  
 (Address) *Johns Hopkins Hosp.*

15- *JAN 18 1915* *ROBERT K. KEATLEY*  
 Filed *1915* *Chief Clerk*

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *January 16*, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Dec 21* 1914 to *Jan 16* 1915, that I saw him alive on *Jan 16* 1915, and that death occurred, on the date stated above, at *10:35* pm.

The CAUSE OF DEATH\* was as follows: *Chronic Myocarditis & Acute Cardiac Dilatation*

(Duration) *2* yrs. *1* mos. *1* ds.  
 CONTRIBUTORY (Secondary) *Enlarged Prostate*

(Signed) *William H. H. H.* M. D.  
*Jan 18 1915* (Address) *Johns Hopkins Hosp.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *26* ds. In the State *7* yrs. *2* mos. *26* ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence *Macon, N. C.*

19-PLACE OF BURIAL OR REMOVAL, *Macon N. C.* DATE OF BURIAL, *Jan 18...*, 1915.

20-UNDERTAKER *Albert P. Fuller* ADDRESS *321 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

ST.: 14 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: 24 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JAN 18 1915

ROBERT . KRABER,

Filed.....

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h or alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

(Duration).....

CONTRIBUTORY.....  
(Secondary)

(Duration).....

(Signed)..... M. D.

(Address).....

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... In the State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

81996

## CERTIFICATE OF DEATH.

64C81996

1-PLACE OF DEATH  
CITY OF BALTIMORE: (No. *1021 Briecca* ST. *21* WARD)  
2-FULL NAME *Sarah A. Wilkins*  
(Residence in Baltimore: No. *1021 Briecca* St.; *63* yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*  
6-DATE OF BIRTH, *April 1*, 18*44*.  
(Month) (Day) (Year)  
7-AGE, *70* yrs., *9* mos., *15* ds. If LESS than 1 day, .... hrs. or .... min.?

8-OCCUPATION:  
(a) Trade, profession, or particular kind of work *House Work*  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Annapolis Md.*  
10-NAME OF FATHER, *William Hood*  
11-BIRTHPLACE OF FATHER (State or Country), *Va.*  
12-MAIDEN NAME OF MOTHER *Unknown*  
13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) *Thomas Wilkins*  
(Address) *1021 Briecca St.*

15- *IAN 18 1915* *ROBERT KRAUTER*  
FIVE 1915 1915 *Robert Krauter*  
Registrar.

### MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 16*, 19*15*.  
(Month) (Day) (Year)  
17- I HEREBY CERTIFY, That I attended deceased from *Jan 13* 19*15*, to *Jan 16* 19*15*, that I saw her alive on *Jan 16* 19*15*, and that death occurred, on the date stated above, at *60* m. The CAUSE OF DEATH\* was as follows:

*Arteriosclerosis*  
(Duration) *9* yrs., *8* mos., *4* ds.  
CONTRIBUTORY (Secondary) *Apoplexy*  
(Duration) .... yrs. .... mos. .... ds.  
(Signed) *J. M. L...* M. D.  
*Jan 13, 1915* (Address) *602 S. O. C. A. St.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Int Oliver Long* DATE OF BURIAL, *Jan 19, 1915*  
20-UNDERTAKER, *E. Schloman & Son* ADDRESS *1239 Kanawha St*

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

## 4-COLOR OR RACE.

5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)

## 6-DATE OF BIRTH.

(Month) (Day) (Year)

## 7-AGE.

If LESS than 1 day.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

## 9-BIRTHPLACE.

(State or Country).

## 10-NAME OF FATHER.

## 11-BIRTHPLACE OF FATHER.

(State or Country).

## 12-MAIDEN NAME OF MOTHER.

## 13-BIRTHPLACE OF MOTHER.

(State or Country).

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JAN 18 1915

ROBERT KRAVYTS,

Filed..... 191. Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

(Month) (Day) (Year)

## 17- I HEREBY CERTIFY, That I attended deceased from

July 6 1914 to Jan 15 1915.

that I saw him alive on Jan 15 1915.

and that death occurred, on the date stated above, at 5:18 p.m.

The CAUSE OF DEATH\* was as follows:

asthma  
Bronchitis  
(Duration) yrs. 6 mos. 15 ds.CONTRIBUTORY  
(Secondary)

(Duration) yrs. 6 mos. 15 ds.

(Signed) L. G. M. Kermack, M. D.

Jan 15 1915 (Address) 708 E. 12th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL.

## DATE OF BURIAL.

Crownland Will Balt Co Jan 18, 1915.

## 20-UNDERTAKER

## ADDRESS

Geo H Hooper 609 Little Mount St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C81998

## CERTIFICATE OF DEATH.

X 87

C81998

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

## 2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

male

## 4-COLOR OR RACE

white

## 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

## 6-DATE OF BIRTH

May 16, 1868  
(Month) (Day) (Year)

## 7-AGE

46 yrs. 8 mos. 0 da.

If LESS than 1 day,

...hrs. or ...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Driver

## 9-BIRTHPLACE, (State or Country),

Germany

## 10-NAME OF FATHER,

Don't know.

## 11-BIRTHPLACE OF FATHER (State or Country),

Don't know.

## 12-MAIDEN NAME OF MOTHER

Don't know.

## 13-BIRTHPLACE OF MOTHER (State or Country),

Don't know.

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. F. Sadowski

(Address)

705 S. Ann St.

## 15-

JAN 18 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

January 16, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 14 1915, to Jan. 16 1915, that I saw him alive on Jan. 16 1915, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Septic pneumonia

(Duration) yrs. mos. 3 da.

## CONTRIBUTORY (Secondary)

Stenosis of Aorta

(Duration) yrs. mos. 10 da.

(Signed) H. N. Warner M. D.

Jan. 17, 1915. (Address) St. Joseph's Hosp.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

At home  
Canton, Balty. Co.

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Holy Rosary

Jan. 17, 1915.

Burial Permit Clerk

ADDRESS

M. F. Sadowski

705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C81999

## HEALTH DEPARTMENT--CITY OF BALTIMORE

C81999

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

704 S. Luzerne

St.:

WARD)

2-FULL NAME

Mary Graft

(Residence in Baltimore: No.

704 S. Luzerne

St.:

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

WIDOWED

DIVORCED

(Write the word)

6-DATE OF BIRTH

Dec 8

1849

(Month)

(Day)

(Year)

7-AGE

65

yrs.

mos.

ds.

or

min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Janitor.

9-BIRTHPLACE  
(State or country)

Germany

10-NAME OF FATHER

John H. Burkhardt

11-BIRTHPLACE OF FATHER  
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Dora Knapp

13-BIRTHPLACE OF MOTHER  
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Burkhardt

(Address)

704 S. Luzerne

## MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan

19

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 16, 1915

to,

Jan 17, 1915

that I saw her alive on

Jan 17

1915

and that death occurred, on the date stated above, at 3:30 am.

The CAUSE OF DEATH\* was as follows:

Lobular Pneumonia

Contributory  
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

1/18

1915

(Address)

279 Eastern

M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

ds.

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McConnell Ave

Jan 19, 1915

20-UNDERTAKER

L. Herwig &amp; Co

ADDRESS

2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 18 1915

ROBERT K. KRAMER,  
Burial Permit Clerk

REGISTRAR



C82000

HEALTH DEPARTMENT—CITY OF BALTIMORE

C82000

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garrett Hospital for Children* ST.; *186* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Helen Margaret Wolf*

(Residence in Baltimore: No. *1104 W. Lombard* St.; *1* yrs., *6* mos., *0* ds.)

St.; *1* yrs., *6* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

*Female*

4-COLOR OR RACE,

*White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

*Single*

6-DATE OF BIRTH,

*July 17, 1913*  
(Month) (Day) (Year)

7-AGE,

*1* yrs., *6* mos., *0* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*None*

9-BIRTHPLACE, (State or Country),

*Balto. Md.*

10-NAME OF FATHER,

*W. L. Wolf*

11-BIRTHPLACE OF FATHER (State or Country),

*Balto. Md.*

12-MAIDEN NAME OF MOTHER

*R. E. Hunter*

13-BIRTHPLACE OF MOTHER (State or Country),

*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Walter C. Bacon*

(Address) *Garrett Hospital*

15-

*JAN 18 1915*

*ROBERT KRAFTER*

*Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 17, 1915*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 28 1914*, to *Jan 17 1915*, that I saw her alive on *Jan 17 1915*, and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH\* was as follows:

*Milliary Tubercular*

(Duration) *1* yrs., *14* mos., *14* ds.

CONTRIBUTORY (Secondary)

*Cardiac Failure*

(Duration) *1* yrs., *12* mos., *12* ds.

(Signed) *Walter C. Bacon, M. D.*

*1/18/15, 1915* (Address) *Garrett Hospital*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *12* yrs., *6* mos., *12* ds. In the State *1* yrs., *6* mos., *12* ds.

Where was disease contracted, if not at place of death? *1104 W. Lombard*

Former or usual residence *1104 W. Lombard*

19-PLACE OF BURIAL OR REMOVAL,

*St. Peter's Cemetery*

UNDERTAKER *H. C. Branning & Son*

DATE OF BURIAL,

*Jan 20, 1915*

ADDRESS *517 N. Schroeder St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82001

## HEALTH DEPARTMENT-CITY OF BALTIMORE

C82001

## CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *413 N, Russell* ST. *6* WARD)FULL NAME *Fannie Gregory*(Residence in Baltimore: No. *413 N, Russell St* St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
 DATE OF BIRTH *October 11, 1846*  
 (Month) (Day) (Year)  
 AGE *68* yrs. *3* mos. *6* ds. If LESS than 1 day, hrs. or min.?

## OCCUPATION

(a) Trade, profession, or particular kind of work *House work*  
 (b) General nature of industry, business, or establishment in which employed (or employer)

## BIRTHPLACE (State or country)

*Ireland*PARENTS  
10. NAME OF FATHER*James A. Bromley*

## 11. BIRTHPLACE OF FATHER (State or country)

*Ireland*

## 12. MAIDEN NAME OF MOTHER

*Unknown*

## 13. BIRTHPLACE OF MOTHER (State or country)

*4*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas B. Gregory*(Address) *413 N. Russell St*

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Jan 17, 1915*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 5, 1915* to *Jan 17, 1915*, that I saw her alive on *Jan 17, 1915*, and that death occurred, on the date stated above, at *3:15 P. m.* The CAUSE OF DEATH\* was as follows:

*Bronchial Pneumonia*(Duration) yrs. mos. *17* ds

## Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *C. C. Hearn* M. D.  
*Jan 17, 1915* (Address) *2600 E. Matthews St*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.  
 Where was disease contracted, If not at place of death?  
 Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Oak Lawn Cemetery Jan 19, 1915*

## FUNERAL UNDERTAKER

## ADDRESS

*Christian Wilkes 2334 Jefferson St*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 18 1915

Filed

, 191

ROBERT J. KRAUTER,

Burial Permit Clerk

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82002

HEALTH DEPARTMENT--CITY OF BALTIMORE

C82002

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 2839 Greenmount Ave ST. 9 WARD)

2-FULL NAME Margarena Helen Dewey Weismiller

(Residence in Baltimore: No. 2839 Greenmount Ave St. 16 yrs. 10 mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH March 15<sup>th</sup>, 1898 (Month) (Day) (Year)

7-AGE 16 yrs. 10 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Stenographer (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, Md.

10-NAME OF FATHER Herman E. Weismiller

11-BIRTHPLACE OF FATHER (State or country) Philadelphia, Penna.

12-MAIDEN NAME OF MOTHER Eva M. Abel

13-BIRTHPLACE OF MOTHER (State or country) Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman E. Weismiller

(Address) 2839 Greenmount Ave

15-

Filed JAN 18 1915 ROBERT J. BURIAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1915 to January 16, 1915, that I saw her alive on January 14, 1915, and that death occurred, on the date stated above, at 5 A m. The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis (Duration) 1 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Bertha E. Tapman M. D. Jan. 16, 1915 (Address) 2733 York Road.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery Jan 17, 1915

20-UNDERTAKER ADDRESS

Mrs. J. E. Evans 428 Charles St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *507 S Sharp* St.; *22* WARD)

2-FULL NAME *Josephine Grace Carniggio*

Residence in Baltimore: No. *507 S. Sharp St.* St.; *5* yrs. *5* mos. *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

### PERSONAL AND STATISTICAL PARTICULARS

### MEDICAL CERTIFICATE OF DEATH

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(Write the word) *Single*

6-DATE OF BIRTH *March 18th 1900.*

(Month)

(Day)

(Year)

7-AGE *14* yrs. *7* mos. *28* ds. or min.?

If LESS than  
1 day, hrs.  
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*House work.*

9-BIRTHPLACE  
(State or country)

*New Orleans*

10-NAME OF FATHER

*Charles Carniggio.*

11-BIRTHPLACE OF FATHER  
(State or country)

*Italy*

12-MAIDEN NAME OF MOTHER

*Rosie Tombinella*

13-BIRTHPLACE OF MOTHER  
(State or country)

*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Rosie Tombinella*

(Address)

*507 S Sharp St.*

16-DATE OF DEATH *1-17-1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *1-10-1915*, to, *1-17-1915*,

that I saw *her* alive on *1-16-1915*,

and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*Trauma of right tibia  
right shoulder & chest  
due to fall down cellar steps.  
Accidental*

(Duration) yrs. mos. *13* ds.

Contributory  
(SECONDARY)

*Traumatic pneumonia*

(Duration) yrs. mos. *7* ds.

(Signed) *S. D. M. M. D.*

*1-17-1915* [Address] *1604 Linden Ave*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Catharine*

*Jan 18 1915*

20-UNDERTAKER

ADDRESS

*John J. Feherty & Son*

*1318 Light St*

JAN 18 1915

FILED

191

COBERT . KRAUTER,

BURIAL PERMIT CLERK

REGISTRAR



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82004

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1228 Hull St

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Robert Stubbs

(Residence in Baltimore: No.

1228 Hull St

St.; yrs. 20 mos. da.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

August 14th, 1876

7-AGE,

38 yrs. 5 mos. 3 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Ticonderoga, New York

10-NAME OF FATHER,

Francis H. Stubbs

11-BIRTHPLACE OF FATHER,

(State or Country),

New Brunswick, N.J.

12-MAIDEN NAME OF MOTHER,

Mary E. Burnett

13-BIRTHPLACE OF MOTHER,

(State or Country),

Ticonderoga, N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

10 E. Fayette St

15-

FILE

JAN 18 1915

HARRY O. ANDREWS,

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 17, 1915

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Nephritis (Acute)

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw. Greenhalgh M. D. (Coroner.)

Jan 17, 1915 (Address) 517 Scott St. Balto. Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cemetery

DATE OF BURIAL,

Jan 19, 1915

20-UNDERTAKER,

Wm. M. Flynn

ADDRESS

1422 Light St

## HEALTH DEPARTMENT—CITY OF BALTIMORE

82005

C82005

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *628 W. Hamburg* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Shaw*Residence in Baltimore: No. *628 W. Hamburg* St.; *40* yrs., .. mos. .. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX

*Male*

## 4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widower*

## 6-DATE OF BIRTH,

*Don't know*  
(Month) (Day) (Year)

## 7-AGE,

*75*

If LESS than 1 day.

...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

## 9-BIRTHPLACE, (State or Country),

*Ireland*

## 10-NAME OF FATHER,

*Don't know*

## 11-BIRTHPLACE OF FATHER (State or Country),

*Don't know*

## 12-MAIDEN NAME OF MOTHER

*Don't know*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Don't know*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Lulee McLaughlin*(Address) *628 W. Hamburg St.*

## 15-

JAN 18 1915 HARRY C. ANDREWS,  
Filed. 191. Burial Permit Clerk.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

*Jan 16, 1915*  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 13* 1915, to *Jan 16* 1915, that I saw him alive on *Jan 16* 1915, and that death occurred, on the date stated above, at *20* m.

The CAUSE OF DEATH\* was as follows:

*Ischemic*(Duration) ... yrs. ... mos. *6* ... ds.CONTRIBUTORY... *Exhaustion*  
(Secondary)(Duration) ... yrs. ... mos. *6* ... ds.(Signed) *J. M. Lempert* M. D.*Jan 18, 1915* (Address) *826 N. Carrollton*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

*Cathedral Cemetery*

## DATE OF BURIAL,

*Jan 19, 1915*

## 20-UNDERTAKER

*H. P. M. Flynn*

## ADDRESS

*1433 Light St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82006

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C82006

## CERTIFICATE OF DEATH.

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 N. Fulton ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

Sadie E. Wolf(Residence in Baltimore: No. 2029 N. Fulton avSt.; 43 yrs., 4 mos., 9 ds)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX,

Female

## 4-COLOR OR RACE,

White5-SINGLE, Married  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Sept. 7<sup>th</sup>, 1871  
(Month) (Day) (Year)

## 7-AGE,

43 yrs., 4 mos., 9 ds.If LESS than 1 day,  
...hrs. or...min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular  
kind of work.....(b) General nature of industry, business,  
or establishment in which  
employed (or employer).....9-BIRTHPLACE,  
(State or Country),10-NAME OF  
FATHER,11-BIRTHPLACE  
OF FATHER  
(State or Country),12-MAIDEN NAME  
OF MOTHER13-BIRTHPLACE  
OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Wolf(Address) 2029 N. Fulton av.

## 15-

Filed JAN 18 1915 1915 Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH,

January 16<sup>th</sup>, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from  
Jan-14<sup>th</sup> 1915, to Jan-16 1915,  
that I saw her alive on Jan 16 1915,  
and that death occurred, on the date stated above, at 6.10 P.M.

The CAUSE OF DEATH\* was as follows:

Lobar PneumoniaDuration) yrs. mos. 3 ds.  
18- CONTRIBUTORY  
(Secondary) Asphixia AnthonisDuration) yrs. mos. ds.  
(Signed) Frank Jones M. D.Jan 17, 1915 (Address) 2802 Rock\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,  
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

New Cathedral Jan 17, 1915

## 20-UNDERTAKER

G. F. Walker

## ADDRESS

723 W. 9th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C82007

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1622 Keyser*)

ST. *8* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Anthony Grossman*

(Residence in Baltimore: No. *1622 Keyser*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Male*

4-COLOR OR RACE,

*White*

5-SINGLE,

*Married*  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

6-DATE OF BIRTH,

*Sept 13, 1862*  
(Month) (Day) (Year)

7-AGE.

*52* yrs. *4* mos. *3* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer*

9-BIRTHPLACE,

(State or Country),

*MD*

10-NAME OF FATHER,

*Nicholas Grossman*

11-BIRTHPLACE OF FATHER

(State or Country),

*Germany*

12-MAIDEN NAME OF MOTHER

*Anna B Bayer*

13-BIRTHPLACE OF MOTHER

(State or Country),

*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Anna Grossman*  
*1622 Keyser St*

*HARRY O. ANDREWS,*

Filed.....

191.....

*Marial Permitt Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Jan 17, 1915*  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

*Inquest* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH\* was as follows:

*Organic Heart Disease*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elyah L. Russell* M. D.

(Coroner.)

*Jan 17, 1915* (Address) *423 N Broadway*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer Ch*

*Jan 19, 1915*

20-UNDERTAKER

*Harry W. Cohen*

ADDRESS

*1948 W. 1st St*



## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *319 Park av*

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Michel E. Parscy*(Residence in Baltimore: No. *319 Park av*

—Str.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

SEX.

*Male*

4-COLOR OR RACE.

*White*5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.) *Married*

6-DATE OF BIRTH.

*Aug 13th*, 1858  
(Month) (Day) (Year)

7-AGE,

*56* yrs. *4* mos. *16* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Insurance Agent*9-BIRTHPLACE,  
(State or Country),*Maryland*

10-NAME OF FATHER,

*William Parscy*11-BIRTHPLACE OF FATHER  
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Mary Myers*13-BIRTHPLACE OF MOTHER  
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Wilson*(Address) *319 Park av*

15-

Filed

JAN 18 1915

HARRY C. ANDREWS,  
Bureau of Health Statistics

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*January 15th*, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 12* 1914, to *January 15* 1915, that I saw him alive on *January 14* 1915, and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH\* was as follows:

*Sclerosis Liver**over 2 months* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

*Abdominal Aneurysm**2 yrs.* (Duration) yrs. mos. ds.

(Signed)

*John T. Lullenger* M. D.*Jan 16th* 1915 (Address) *1002 E. Lombard*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*St. Peter's Cemetery**Jan. 17, 1915*

20-UNDERTAKER

ADDRESS

*John J. Wild 12000 Lombard St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82009

HEALTH DEPARTMENT-CITY OF BALTIMORE

C82009

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)

(Signed) J. H. O'Donnell M. D.

(Address) 107 E. West St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JAN 18 1915

Filed

191

HARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

## HEALTH DEPARTMENT—CITY OF BALTIMORE

C82010

## CERTIFICATE OF DEATH.

91

C82010

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *712 E. Waverly* ST. *1* WARD)

## 3-FULL NAME

(Residence in Baltimore: No. *712 E. Waverly* St.; *35* yrs., *0* mos., *0* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JAN 18 1915

HARRY O. ANDERSON,

Burial Permit Clerk  
Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82011

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

C82011

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 N Broadway ST. 7

REGISTERED NO. C

2-FULL NAME Harry R. Walker

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1040 N Broadway

St.; yrs., mos., da.)

## PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,  
MARRIED,  
WIDOWER,  
OR DIVORCED.  
(Write the word.)

Single

6-DATE OF BIRTH,

Mar 30

(Month)

(Day)

1915  
(Year)

7-AGE,

yrs. 18 mos. 18 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

Md

10-NAME OF FATHER

Harry R. Walker

11-BIRTHPLACE OF FATHER  
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Julia E. Akers

13-BIRTHPLACE OF MOTHER  
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry R. Walker

(Address) 1040 N Broadway

15-

JAN 18 1915

HARRY O. ANKERS,

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

1915  
(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 13 1915, to Jan 17 1915,

that I saw him alive on Jan 17 1915,

and that death occurred, on the date stated above, at 11<sup>00</sup> a.m.

The CAUSE OF DEATH\* was as follows:

Respiratory Failure

(Duration)

yrs.

mos.

da.

CONTRIBUTORY  
(Secondary)

(Duration)

yrs.

mos.

da.

(Signed)

John B. Leman M. D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Caudon Park  
Chenworth & Son  
347 Chestnut  
av



C82012

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH.

REGISTERED NO. C

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No. *18 Allan Avenue* St.; yrs. mos. ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

*Male*

## 4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

## 6-DATE OF BIRTH.

*Feb 22*, 1840.  
(Month) (Day) (Year)

## 7-AGE.

*75* yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Librarian*

## 9-BIRTHPLACE, (State or Country),

*Ind*

## PARENTS.

## 10-NAME OF FATHER,

*Saml nr*

## 11-BIRTHPLACE OF FATHER (State or Country)

*Ind nr*

## 12-MAIDEN NAME OF MOTHER

*Saml nr*

## 13-BIRTHPLACE OF MOTHER (State or Country),

*Ind nr*

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William M. Drongos*(Address) *18 Allan Ave*

## 15-

JAN 18 1915

HARRY O. ANDREWS,

BRIAL PERMIT GLOF

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH.

*Jan 17*, 1915.  
(Month) (Day) (Year)

## 17-I HEREBY CERTIFY, That I attended deceased from

*Dec 24* 1915, to *Jan 17* 1915.that I saw him alive on *Jan 17* 1915,and that death occurred, on the date stated above, at *9:15 P.*

The CAUSE OF DEATH\* was as follows:

*Acute Gastritis*  
*Accidental*  
*Fell on ice*

(Duration) yrs. mos. ds.

## CONTRIBUTORY (Secondary)

*Fractured hip (left)*  
(Duration) yrs. mos. ds.

## (Signed)

*W. M. Drongos* M. D.  
*1-17*, 1915 (Address) *May, Genl Hosp*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds. *24* *24*Where was disease contracted, if not at place of death? *at home*Former or usual residence *18 Allan Ave*

## 19-PLACE OF BURIAL OR REMOVAL.

*W. M. Drongos*

## DATE OF BURIAL.

## 20-UNDERTAKER

*W. M. Drongos*

## ADDRESS

*5028 North Ave*

16. b. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL STATE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

82013

# HEALTH DEPARTMENT—CITY OF BALTIMORE

82013

## CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. ....)

2-FULL NAME

(Residence in Baltimore: No. ....)

Mercy Hospital 10  
Annie L. Lembach  
951 Forrest St.  
Mercy Hospital

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

### PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.  
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,  
... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,  
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JAN 18 1915

HARRY O. ANDREWS,

Registrar.

### CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January 18, 1915.  
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that said deceased came to death thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH\* was as follows:

Suicide. Discharge of Mercury  
by mouth.  
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY  
(Secondary)

(Signed) ... M. D.  
(Coroner.)  
Jan. 18, 1915. (Address) 18 N. Franklin St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place 15 hours In the  
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 951 Forrest St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western View Jan. 21, 1915.  
ADDRESS  
502 E. Madison





N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

C82015

## CERTIFICATE OF DEATH

93 C82015

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 322 W. Preston ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

2-FULL NAME Mark Potter

(Residence in Baltimore: No. 322 W. Preston St. St.; 48 yrs. — mos. — ds.)

### PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE col 5-SINGLE widowed  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6-DATE OF BIRTH — — 1867  
(Month) (Day) (Year)

7-AGE 48 yrs. — mos. — ds. or — min.?  
If LESS than 1 day, — hrs.

8-OCCUPATION  
(a) Trade, profession or particular kind of work Oyster Shucker  
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE  
(State or country) Maryland

PARENTS  
10-NAME OF FATHER George Potter  
11-BIRTHPLACE OF FATHER MD  
12-MAIDEN NAME OF MOTHER Elizabeth Williams  
13-BIRTHPLACE OF MOTHER MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Georgie Irony  
(Address) 322 W. Preston St.

JAN 19 1915

Filed —, 191

ROBERT KRAUTER,  
Burial Permit Clerk,  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January 17, 1915  
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31, 1914, to Jan 17, 1915, that I saw him alive on Jan 16, 1915, and that death occurred, on the date stated above, at 9 A. m.  
The CAUSE OF DEATH\* was as follows:

Pleurisy

(Duration) — yrs. — mos. 18 ds.

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) H. C. Belter M. D.

Jan 18, 1915 [Address] 347 W. Preston St.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wt Auburn Jan 19, 1915

20-UNDERTAKER ADDRESS

Samuel T. Hensley 578 W. Biddle St.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

C82016

## CERTIFICATE OF DEATH.

103 C82016

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Parkhill ST.; 9 WARD)

## 2-FULL NAME

(Residence in Baltimore: No. 1909 Parkhill St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 2-SEX,

Male

## 4-COLOR OR RACE,

white5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED.  
(Write the word.)  
Infant

## 6-DATE OF BIRTH,

November 19, 1914  
(Month) (Day) (Year)

## 7-AGE,

0 yrs. 0 mos. 30 ds.If LESS than 1 day,  
...hrs. or....min.?

## 8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Infant9-BIRTHPLACE,  
(State or Country),Balto Md

## 10-NAME OF FATHER,

Oliver E. Hove11-BIRTHPLACE OF FATHER  
(State or Country),Wash. D.C.

## 12-MAIDEN NAME OF MOTHER

Bruna Splaenger13-BIRTHPLACE OF MOTHER  
(State or Country),York Pa

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Oliver E. Hove(Address).....1909 Parkhill

## 15-

JAN 19 1915

Filed..... 191

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

Jan. 18, 1915  
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec. 19<sup>th</sup> 1914 to Jan. 18<sup>th</sup> 1915, that I saw him alive on Jan. 18<sup>th</sup> 1915, and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH\* was as follows:

Acute hemorrhage occurring  
secondary to embolism without  
any premonition.  
(Duration).....yrs. 1 mos. ....ds.CONTRIBUTORY  
(Secondary)(Signed).....Chas. E. M. D.  
Jan. 18<sup>th</sup> 1915 (Address).....570 E. 20th St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

York Penna Jan 20, 1915

## 20-UNDERTAKER

## ADDRESS

Wm. Cook 101 E. N. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

82017 HEALTH DEPARTMENT—CITY OF BALTIMORE

175082017

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

Mary Hospital

St.:

18

WARD)

2-FULL NAME

Henry D. Coles

(Residence in Baltimore: No.

1112 Newmans Court

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-~~SEX~~ MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

March

9

1873

(Month)

(Day)

(Year)

7-AGE,

41

10

6

ds.

10 LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Driver

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

City

10-NAME OF FATHER,

Asa Coles

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Margaret Kenner

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lara Coles (wife)

(Address)

1112 Newmans Court

15-

JAN 19 1915

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

January

18, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquest.

thereon and from the evidence obtained by said

(Inquest, in

that said deceased came to death

on the day stated above.

The CAUSE OF DEATH\* was as follows:

Accident - thrown from wagon by jolt & run over by wheels wagon

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. H. Chambers

(Coroner)

Jan. 18, 1915

(Address) 18 W. Franklin St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery

Jan 19, 1915

20-UNDERTAKER

ADDRESS

John J. Fields 1200 W. Lombard St

WRITE PRINTED, WITH CORRECTIONS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C82018

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C82018

PLACE OF DEATH

1418 Ectaw Place

CITY OF BALTIMORE (No.

Harold A. Kelly Harp St. Euc.

WARD)

FULL NAME

Maximo Caras

Residence in Baltimore: No.

1418 Ectaw Place

Str.

yrs.

mos.

24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

Married

DATE OF BIRTH

Oct.

4

1866

AGE

48

yrs.

3

mos.

10

ds.

If LESS than  
1 day, hrs.  
or min.?

OCCUPATION

(a) Trade, profession, or  
particular kind of work  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Cigar dealer

BIRTHPLACE  
(State or country)

Spain

NAME OF  
FATHER

Caras

BIRTHPLACE  
OF FATHER  
(State or country)

Spain

MAIDEN NAME  
OF MOTHER

Unknown

BIRTHPLACE  
OF MOTHER  
(State or country)

Spain

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Marie Caras (wif.)

(Address)

1520 - 13th. Ave  
Tampa - Fla.

JAN 19 1915

ROBERT KRAUTER

Surial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan.

18

1915

I HEREBY CERTIFY, That I attended deceased from  
Nov 25, 1915, to Jan 18, 1915,  
that I saw him alive on Jan 18, 1915,  
and that death occurred, on the date stated above, at 6 p. m.  
The CAUSE OF DEATH\* was as follows:

Carcinoma of larynx

Contributory  
(SECONDARY)

(Signed),

Robert M. Lewis

M. D.

1-18, 1915. (Address) 1418 Ectaw Place Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 24 ds. State yrs. 1 mos. 24 ds.

Where was disease contracted, Tampa Fla.

If not at place of death?

Former or usual residence Tampa Fla.

PLACE OF BURIAL OR REMOVAL

Tampa Florida

DATE OF BURIAL

Jan 19, 1914

ADDRESS

Chas G. Black 1201 W. Mulberry



CITY HALL  
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

## CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 5<sup>th</sup> DAY June  
OF 1964 THE MICROPHOTOGRAPHS APPEARING  
HEREIN STARTING WITH C 81431- <sup>Reg. Dec. 29, 1914</sup> AND  
ENDING WITH C-82018 <sup>Reg. JAN. 19, 1915</sup> ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE  
RECORDS OF THE DEPARTMENT OF Health  
BUREAU OF Vital Statistics AS DELIVERED  
IN THE REGULAR COURSE OF BUSINESS FOR  
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM  
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU  
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC  
COPY.

CAMERA OPERATOR: D. McFaul





**END OF REEL**